LOUISIANA DEPARTMENT OF HEALTH

2025 External Quality Review Compliance Review

for

Aetna Better Health

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review (CR) activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Apr 1, 2025.

Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for Aetna Better Health (ABH). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	10	4	1	71%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	6	13	0	32%
IX	Subcontractual Relationships and Delegation	6	6	3	3	0	50%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	36	1	1	97%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		**227**	**217**	**189**	**28**	**10**	**87%**

M=*Met*, ***NM***=*Not Met,* ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

Table 2-1—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓				-	✓	✓	✓
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

[1] The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an information systems (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025-September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

3. Corrective Action Plan Process

ABH is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for ABH to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring ABH into full compliance with the deficient requirements. ABH must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). ABH's CAP template and evidence of implementation must be submitted to the HSAG SAFE site **no later than 60 calendar days from receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that ABH will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought ABH into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by ABH in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
+	The MCE's policies and procedures ensured that the MCE did not request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. Furthermore, the MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations.
+	The MCE received 100 percent compliance with Standard II—Member Rights and Confidentiality, indicating that members were receiving timely and adequate access to information that could assist them in accessing care and services.
+	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
+	The MCE consistently met timeliness requirements for prior authorization decisions. Additionally, the MCE received 100 percent compliance with Standard VII—Coverage and Authorization of Services, demonstrating that the MCE had a thorough and comprehensive approach for review, authorization, and denial of services.
+	The MCE effectively adopted practice guidelines in consensus with network providers and had a system in place for dissemination to providers and members. In addition, the MCE received 100 percent compliance with Standard X—Practice Guidelines.
+	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had processes in place for how information is captured, processed, and stored in the MCE's data warehouse. The MCE had the capability to capture and report on utilization patterns, claims, complaints, grievances, appeals, and provider and member demographic information.
+	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.
+	The MCE received 100 percent compliance with Standard XIV—Program Integrity, demonstrating that the MCE had appropriate processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. Furthermore, the MCE developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations	
−	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.

Appendix B. 2025 Compliance Review Tool

This appendix includes the completed review tool that HSAG used to evaluate ABH's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring ABH's performance into full compliance.

Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the MCE		
1. The MCE may request disenrollment of a member in the following circumstances: a. *When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department* b. *Upon termination or expiration of the Contract* c. *Death of the member* d. *Confinement of the member in a facility or institution when confinement is not a covered service under the Contract* PAHP: a. *The Contractor may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).* PIHP: a. *The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.* 42 CFR §438.56(b)(1) 42 CFR §457.1212 MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6	**HSAG Required Evidence:** • Policies and procedures • State-specific workflow for MCE-initiated disenrollment requests • Member materials, such as the member handbook • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • S1R1-A-LA 4500.86 Member Disenrollment/Disruptive Member Transfer • S1R1 - 2024 Member Handbook • S1R1-RB Disenrollment Form • S1R1-MCO Disenrollment Request • S1R1-Member Involuntary Disenrollment – Beauchamp • S1R1 - Grievance Procedure Flowchart	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: All enrollment and disenrollment transactions are governed exclusively by the Louisiana Department of Health (LDH) and its designated enrollment broker, Maximus. Aetna Better Health of Louisiana receives enrollment and disenrollment data via the state-generated 834 transaction file. The plan does not have the authority to independently enroll or disenroll members and relies solely on the data provided by LDH and Maximus to administer member eligibility.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE does not request disenrollment because of: MCO & PAHP: a. An adverse change in the member's health status; or b. Because of the member's health diagnosis c. The member's utilization of medical services d. The member's diminished mental capacity e. The member's pre-existing medical condition f. The member's refusal of medical care or diagnostic testing g. The member's attempt to exercise his/her rights under the Contractor's Grievance system h. The member's attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either this particular member or other members). PIHP: a. The member's adverse change in health status	**HSAG Required Evidence:** • Policies and procedures • Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • S1R2-A-LA 4500.35 Member Rights and Responsibilities, pg. 2 • S1R2-A-LA 4500.86 Member Disenrollment/Disruptive Member Transfer, pgs. 5-6 • S1R2 - A-LA 4400.15 Enrollee Member Enrollment • S1R12 - Member Involuntary Disenrollment - Washington (SFH) - MCE Requested Disenrollment	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
b. The member's utilization of medical services c. The member's diminished mental capacity d. The member's uncooperative or disruptive behavior resulting from his or her special needs 42 CFR §438.56(b)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5	• S1R3-Member Involuntary Disenrollment – Beauchamp – MCE Requested Disenrollment	
MCE Description of Process: ABH refers all member disenrollment requests to the Louisiana Department of Health (LDH), which retains sole authority over enrollment and disenrollment decisions. In 2024, ABHLA submitted two formal requests for involuntary disenrollments to LDH in accordance with contractual provisions, citing instances of member behavior involving abuse of staff that were not attributable to any diagnosed condition or special need. These requests were made in alignment with state contract and only after internal review and documentation of the incidents.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract. MCO & PAHP: a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker. PIHP: a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request **Evidence as Submitted by the MCE:** • S1R3-A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
not disenroll Coordinated System of Care (CSoC) members for any reason other than discharge from CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge. 42 CFR §438.56(b)(3) 42 CFR §457.1212 MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6	• S1R3-Member Involuntary Disenrollment – Beauchamp1 • S1R3-RB Disenrollment Request Form • S1R3 - Member Disenrollment Training Slides	
MCE Description of Process: ABH strictly adheres to contractual requirements and does not request member disenrollment for any reason not expressly permitted under the state contract. All staff involved in member interactions are trained on the limited circumstances under which a disenrollment request may be submitted to the Louisiana Department of Health (LDH). Furthermore, all involuntary disenrollment requests undergo thorough internal review by plan leadership and the Compliance department to ensure appropriateness and compliance prior to submission to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Disenrollment Requested by the Member		
4. The member may request disenrollment from the MCE as follows: a. Without cause, at the following times: MCO: i. During the disenrollment period offered to Enrollees at the start of the contract.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S1R4-A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
ii. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter. v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. PAHP: i. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter.	• S1R4 - 2024 Member handbook, pgs. 16, 81	

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212 MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA		
MCE Description of Process: ABH ensures that members are informed of their right to request disenrollment under specific circumstances. This information is clearly outlined in both the Member Handbook and internal policies. These materials are reviewed annually and updated to maintain compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Procedures for Disenrollment		
5. The following are causes for disenrollment: MCO: a. The member moves out of the MCE's service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; c. The member needs related services to be performed at the same time; not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; f. The Contract between the MCE and LDH is terminated; g. The member's active specialized behavioral health provider ceases to contract with the MCE for reasons other than noncompliance with the Network Provider Agreement of this Contract; or h. Any other reason deemed to be valid by LDH and/or its agent. PAHP: a. The MCE does not (due to moral or religious objections) cover the service the member seeks;	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S1R5-A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer • S1R5 - 2024 Member handbook, pgs. 81-82 • S1R5 - A-LA 3100.90 Enrollee Grievance Policy	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
b. The member needs related services to be performed at the same time, not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; c. Poor quality of care; d. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; e. The Contract between the MCE and LDH is terminated; f. Any other reason deemed to be valid by LDH and/or its agent. 42 CFR §438.56(d)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA		
MCE Description of Process: ABH receives all enrollment and disenrollment data exclusively through the state-issued 834 transaction file. LDH maintains full authority over enrollment processes. Members retain the right to request disenrollment for cause, as defined by LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that ABH add language that states "the member moves out of the MCE's service area" to the "With Cause" disenrollment list on the Member Disenrollment/Disruptive Member Transfer policy and any other applicable documents.		
Required Actions: No action required.		
6. The member must request disenrollment by submitting an oral or written request (as required by the State): a. To the State or its agent; or	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
b. To the MCE, if the State permits MCEs to process disenrollment requests. 42 CFR §438.56(d)(1) 42 CFR §457.1212 MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA	• Workflow delineating State and MCE responsibilities • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) **Evidence as Submitted by the MCE:** • S1R6-A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer • S1R6 - 2024 Member handbook, pg. 81 of 100	☐ NA
MCE Description of Process: Members seeking to disenroll from ABH are referred to the Louisiana Department of Health (LDH), which retains sole authority over all enrollment and disenrollment decisions. ABH provides guidance and materials to members on how to initiate the disenrollment process through the appropriate state channels.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. When the MCE's contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State. 42 CFR §438.56(d)(3)(i) 42 CFR §457.1212 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter, review conducted by the MCE, decision made by the MCE, reporting to the State) **Evidence as Submitted by the MCE:** • Not Applicable to ABH.	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Not Applicable - LDH retains exclusive authority over all enrollment and disenrollment decisions.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The State retains authority over all disenrollment decisions, so the MCE is not able to process a disenrollment request; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Use of the MCE's Grievance Process		
8. (If the State contract requires) The member must seek redress through the MCE's grievance process before making a determination on the member's request: a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State. b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request. 42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212 MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Three case examples of a member request for disenrollment grievance record, including the resolution letter • Referrals to the State for member termination from MCE • Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) **Evidence as Submitted by the MCE:** • Not applicable to ABH.	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Not applicable to ABH, the state contract does not require the provision of grievance process when receiving a request from a member to disenroll from the plan.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The State contract does not require a grievance process as described in these requirements; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. If the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved. 42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212 MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • Not Applicable to ABH.	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Not applicable – ABH does not make determinations regarding member disenrollment; all such decisions are the sole responsibility of the Louisiana Department of Health (LDH). Enrollment and disenrollment data are transmitted to ABH via the 834 file, which is generated and sent electronically by Maximus, the state's enrollment broker. The 834 file serves as the authoritative source for member eligibility and enrollment status. ABH only processes disenrollments upon official notification from the state.		
HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Enrollment		
10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems. MCO and PAHP:	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • S1R10 – A-LA 4400.15 Enrollee Member Enrollment, pg. 2	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
a. *The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 CFR §438.50(a).* PIHP: a. *The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member's choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility.* 42 CFR §438.3(d)(1) MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2		
MCE Description of Process: ABH does not make determinations regarding member disenrollment; such decisions are exclusively made by LDH. Enrollment and disenrollment data are communicated to ABH through the state-generated 834 transaction file. In alignment with contractual requirements, it is ABH's policy to accept all members in the order in which they are assigned by the state, without any form of restriction or prescreening.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. 42 CFR §438.3(d)(3-4) MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4	**HSAG Required Evidence:** • Enrollment policies and procedures • Member handbook **Evidence as Submitted by the MCE:** • S1R11 – 2024 Member Handbook, pg. 99 • S1R11-A-LA 4500.35 Member Rights and Responsibilities • S1R11 - A-LA 4400.15 Enrollee Member Enrollment	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABH maintains a strict nondiscrimination policy that prohibits any form of discrimination based on health status, healthcare needs, race, color, national origin, sex, or disability. Member rights and responsibilities, including the right to equitable and respectful treatment, are communicated upon enrollment and annually thereafter through the Member Handbook.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. If the Department approves the MCE's disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing. MCO: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date of the disenrollment;	**HSAG Required Evidence:** • Enrollment policies and procedures • Member notification letter template **Evidence as Submitted by the MCE:** • S1R12-Member Involuntary Disenrollment - Beauchamp (No SFH)	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
iii. An instruction that the Enrollee choose a new MCO; and iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing. PAHP: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date; iii. An instruction that the enrollee choose a new DBPM; and iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing. 42 CFR §438.56(d)(5) MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA	• S1R12 - Member Involuntary Disenrollment - Washington (SFH) • S1R12 - Amd_4_ABH-Approved_Contract_Packet, pgs. 5-6	
MCE Description of Process: In 2024, the state amended the contract to align with 42 CFR §438.56(d)(5) , which does not specify involuntary disenrollment by the MCO as grounds for a State Fair Hearing. Amendment No. 4 updated the disenrollment process to remove the availability of a State Fair Hearing from enrollees. Prior to Amendment No. 4, when a member was disenrolled, their notice letter contained language referring to a State Fair Hearing. Later in 2024, this language was removed, and the letter was updated to reflect the change. In virtual review, the MCE described its understanding that LDH notifies members of proposed disenrollment (with 30 days advance notice). In accordance with the MCE's contract amendment 4, the MCE generates a member notification letter and omits the state hearing information as directed by the state. The MCE enters the date that the member was disenrolled (according to the 834). The state's notification process does not allow the MCE to give 30 day advance notice in its member notifications.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**100%**

Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2	**HSAG Required Evidence:** • Member rights policy **Evidence as Submitted by the MCE:** • S2R1 A-LA 4500.35 Member Rights and Responsibilities	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABH maintains a policy related to member rights and responsibilities.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it's employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4	**HSAG Required Evidence:** • Policies and Procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms • Grievance log over the time period of review with member rights grievances **Evidence as Submitted by the MCE:** • S2R2 - Grievance log for Calendar Year 2024 • S2R3 HIPAA Privacy Rights and Response, Entire Document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2R3 – Access SOP (Staff training Material) • S2R2 – 2024 Provider Manual, pgs 41-42, 101-105 • S2R2 – 2024 Member Handbook, pgs. 18-19 • S2R2 – A-LA 4500.35 Member Rights and Responsibilities, pg. 3-4.	
MCE Description of Process: ABH has established a process and outlined the requirements necessary for individuals and/or Personal Representatives to make requests to access, account for disclosures of, correct, and/or restrict Protected Health Information (PHI) maintained by CVS Health in accordance with the Health Insurance Portability and Accountability Act (HIPAA).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Specific Rights		
3. The MCE complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the MCE:** • S2R3 HIPAA Privacy Rights and Response, pg. 2 Sections II and IV, pg. 4-6, Section III, pg. 8, Section V • S2R3 Access SOP • S2R2 – A-LA 4500.35 Member Rights and Responsibilities	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABH complies with the requirements set out on the Member Rights Checklist, by maintaining policies and employee training.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. While the MCE responded to the checklist with citations of the member handbook, this documentation was insufficient to demonstrate that the MCE complied with the requirements for the checklist. However, compliance was determined during virtual review. The MCE demonstrated its procedures for ensuring compliance with member rights and referred the reviewer to additional documentation that verified the MCE's compliance.		
Required Actions: No action required.		
General Rule		
4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO. b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520. c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530.	**HSAG Required Evidence:** • Policies and procedures (should address all components of 45 CFR part 164 subpart E) • Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Staff training materials **Evidence as Submitted by the MCE:** • 2024 Enterprise Privacy Path, Entire Document • S2R4 General HIPAA Privacy Policy, Entire Document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. 42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12	• S2R4 Privacy Complaints, pgs 1-2, Section 2-3 • S2R4 use and Disclosure of PHI, Entire Document • S2R4 HIPAA Privacy Rights and Response, Entire Document • S2R4 Notice of Privacy Practices, Entire Document • S2R4 Safeguards, pg.3, Section I, 1-3 • S2R4 Privacy Adherence and Protecting PHI ePHI, Entire Document • S2R4 – LA Medicaid Provider Contract Template, pgs. 9, 15-16.	
MCE Description of Process: ABH establishes and maintains a Privacy Program for Protected Health Information (PHI) and electronic Protected Health Information (ePHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA), and other applicable federal, state, and/or local laws and regulations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosure of PHI		
5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows: a. To the individual.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2	**Evidence as Submitted by the MCE:** • 2024 Enterprise Privacy Path, Entire Document • S2R5 Use and Disclosure of PHI, Entire Document • S2R5 Business Associate Agreement Template, Entire Document • S2R5 Contracting Requirements, Entire Document • S2R4 - ABHLA Medicaid Provider Contract Template • S2R5 - ABHLA--HFI--RCA	
MCE Description of Process: ABH may use or disclose Protected Health Information (PHI) without an individual's authorization for purposes of treatment, payment, or health care operations (TPO), as permitted under the Health Insurance Portability and Accountability Act (HIPAA).		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Unless a use or disclosure is required by law or otherwise permitted without authorization under applicable regulations, ABH will obtain a valid authorization from the individual or the individual's personal representative prior to any such use or disclosure of PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCE's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • S2R6 Business Associate Agreement Template, pg 3, Section h, j, l • S2R6 Contracting Requirements, pg 2, Sections i, j, l • S2R6 HIPAA Privacy Rights and response, pg2, section II-III, pgs 4-7, Sections III-IV • S2R6 General HIPAA Privacy Policy, pg 5, Section b • S2R6 Accounting of Disclosure Direction.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: PHI/ePHI is required to be disclosed to: (i) an individual upon request and/or for an accounting of disclosures and, (ii) the Secretary of Health and Human Services to determine HIPAA compliance. ABH complies with this requirement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Minimum Necessary		
7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Three examples of requests for PHI from another covered entity (e.g., member's previous MCE, dental benefits administrator, provider) **Evidence as Submitted by the MCE:** • 2024 Enterprise Privacy Path, pg 13 • S2R7 General HIPAA Privacy Policy, pgs 4-5, Section 4a • S2R7 use and Disclosure of PHI, pg2, Section II, 1-4 • S2R7 – Examples of SFTP for Transfer of PHI	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: All use and disclosure of PHI/ePHI must meet the minimum necessary principle, meaning utilizing and sharing only the PHI/e/PHI that is required for the purpose of processing, i.e., only storing, accessing, transferring the PHI data fields needed for use. ABHLA utilizes SFTP methods and Secure Email to transmit information containing PHI. The state regulator (LDH) routinely requests information containing PHI; these requests are fulfilled by ABHLA utilizing Salesforce to securely transfer documents.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Evidence as Submitted by the MCE:** • 2024 Enterprise Privacy Path, page 13 • S2R8 use and Disclosure of PHI, pg 2, Section II, 5. pg 4, Section V.	

MCE Description of Process: The principle of minimum necessary use and disclosure of PHI does NOT apply to:

1. Disclosures to a health care provider for treatment purposes.
2. Disclosures to the authenticated individual who is the subject of the information.
3. Uses and disclosures made pursuant to a valid authorization.
4. Disclosures to the U.S. Department of Health and Human Services when disclosure of information is required under the HIPAA Privacy Rule for enforcement purposes.
5. Uses or disclosures required for compliance with the HIPAA Administrative Simplification Rules.
6. Uses or disclosures required by other law, in accordance with the *Exceptions* section below.

ABH is not required to obtain permission from individuals for use or disclosure of the individual's PHI in the instances outlined below:

a. Applicable Federal/State Law.
b. Judicial/Administrative Proceedings

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
c. Law Enforcement d. Specialized Government Functions e. Public Health Activities. f. Health Oversight Agency g. Compliance with Labor Laws h. Health & Safety i. Personal Representatives j. Coroner/Medical Examiners k. Funeral Directors l. Organ Procurement Organizations. m. Research Purposes. n. Business Associate Agreements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosures Requiring Authorizations		
9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 **Evidence as Submitted by the MCE:** • 2024 Enterprise Privacy Path	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR Part 164 Subpart E 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• S2R9 Use and Disclosure Authorization form, page 2, Section 7 – last bullet, Section 8 – last statement • S2R9 Use and Disclosure of PHI, page 3, Section III, 2.	
MCE Description of Process: When ABH seeks an individual's authorization for the use or disclosure of Protected Health Information (PHI), a copy of the signed authorization is provided to the individual for their records. ABH may request such authorization in limited circumstances—for example, in connection with certain marketing activities unrelated to the member's health plan or in situations involving the sale of PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Privacy Rights		
10. The MCE complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for privacy protection • Two examples of member's request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request **Evidence as Submitted by the MCE:** • S2R10 HIPAA Privacy Rights and Response, pgs 2-3, Sections V-VI, pgs 8-9, Sections VI-VII	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2R10 HIPAA Confidential Communications SOP • S2R10 Medicaid Confidential Form • S2R10 HIPAA Privacy update directions QNXT • No Privacy Protection requests received (approved or denied) for this plan in 2024	
MCE Description of Process: The HIPAA Member Rights Team will evaluate each request to determine whether to grant the request to the extent that ABH has discretion under applicable law. The HIPAA Member Rights Team will notify the individual of its decision to grant or deny the request within the required timeframe.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCE acts on a request for access no later than 30 days after receipt of the request. b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member. 45 CFR §164.524 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to access PHI • Two examples of member's request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request **Evidence as Submitted by the MCE:** • S2R11 Requests for Access to PHI, pg 1, Section 1. a. • S2R11 HIPAA Privacy Rights and Response, pg 2, Sections II, pgs. 4-6, Section III • S2R11 Access Request Form, Entire Form	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2R11 Access-SOP • S2R11 Medicaid Claim Reporting system • No requests for PHI access were received for ABHLA during CY2024	
MCE Description of Process: The HIPAA Member Rights Team will accept individual requests for access to PHI maintained by Aetna. Upon receipt of a request Aetna will 1) Return the request to the individual with an explanation as to why the request cannot be honored; or 2) Contact the individual and ask for additional information; and/or 3) Provide the records requested. All actions will be completed within the required timeframe.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE complies with the member's right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526. • The MCE acts on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526 42 CFR §457.1110(e) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to amend PHI • Two examples of member's request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request • One example of a denial of an amendment and notification to the member **Evidence as Submitted by the MCE:** • S2R12 HIPAA Privacy Rights and Response, pg.2, Section IV, pg. 8, Section V • S2R12 Amendments to PHI, pg. 1 Section 1, a, vi, pg 3, 5 a	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2R12 HIPAA Amendment Directions • No requests for PHI Amendment received (approved or denied) for this plan	
MCE Description of Process: The HIPAA Member Rights Team will accept individual requests for amendments to PHI maintained by Aetna. Upon receipt of a request Aetna will 1) Return the request to the individual with an explanation of why the request cannot be honored; or 2) Contact the individual to ask for additional information; and/or 3) work with the applicable business area to ensure appropriate change is made in the relevant system(s). All action will be completed within the required timeframe.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. The MCE complies with the member's right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCE acts on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for an accounting of disclosures of PHI • Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) • Two examples of member's request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request • Documentation to demonstrate how the record of the accounting of disclosures is retained	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S2R13 Accounting of Disclosure Form, Entire Form • S2R13 HIPAA Privacy Rights and response, pg. 2, Section III, pgs. 6-7, Section IV • S2R13 HUDA – Accounting for Permissible Disclosures, Entire Document • S2R13 Requests for Accounting of Disclosures of PHI, pg. 4, Section 3 a i • S2R13 HIPAA Accounting Directions and Workflow • No requests for accounting of PHI received (approved or denied) for this plan for CY2024	
MCE Description of Process: The HIPAA Member Rights Team will accept individual requests for an accounting of disclosures. Upon receipt of a request Aetna will 1) Return the request to the individual with an explanation as to why the request cannot be honored; or 2) Contact the individual and ask for additional information; and/or 3) Provide the report. All actions will be completed within the required timeframe.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Breach of Unsecured PHI		
14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to have been accessed, acquired, used, or disclosed as a result of such breach.	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. Breach and unsecured PHI are as defined in 45 CFR §164.402. 45 CFR §164.402 45 CFR §164.404(a)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members **Evidence as Submitted by the MCE:** • S2R14 Breach Notification Letter Template • S2R14 Risk Assessment and Breach Tracking Tool, Entire Document • S2R14 General HIPAA Privacy Policy, pg. 14, 11. • S2R14 Breach Notification Policy, pg. 5, Section 8	
MCE Description of Process: If the Privacy Office cannot determine based on its Risk Assessment that there is a low probability that PHI/ePHI and/or PII has been compromised and/or if it determine that the incident constitutes a Breach under applicable state law, subject to any delay required by law enforcement, it will notify affected individuals by first class mail, without unreasonable delay, but in no event later than 60 days after the Breach is discovered or within such shorter time period specified under applicable state law. There were no breaches of unsecured PHI during this time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE. a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any	**HSAG Required Evidence:** • Policies and procedures • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
person, other than the person committing the breach, who is a workforce member or agent of the MCE. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Evidence as Submitted by the MCE:** • S2R15 Corp Breach Notification Policy, pg. 5, Section 8 • S2R15 Risk Assessment and Breach Notification Tracking Tool, Entire Document	
MCE Description of Process: If the Privacy Office cannot determine based on its Risk Assessment that there is a low probability that PHI/ePHI and/or PII has been compromised and/or if it determine that the incident constitutes a Breach under applicable state law, subject to any delay required by law enforcement, it will notify affected individuals by first class mail, without unreasonable delay, but in no event later than 60 days after the Breach is discovered or within such shorter time period specified under applicable state law. The 60-day period will be measured as of the first day on which the Breach is known, or by exercising reasonable diligence should have been known to an Aetna Workforce Member (other than the person committing the Breach) or to a Business Associate of Aetna that is an Agent of Aetna (as determined under Federal common law of an agency). There were no breaches of unsecured PHI during this time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(b) 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members **Evidence as Submitted by the MCE:** • S2R16 Risk Assessment and Breach Tracking Tool	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2R16 Corp Breach Notification Policy, pg. 5, Section 8	
MCE Description of Process: If the Privacy Office cannot determine based on its Risk Assessment that there is a low probability that PHI/ePHI and/or PII has been compromised and/or if it determine that the incident constitutes a Breach under applicable state law, subject to any delay required by law enforcement, it will notify affected individuals by first class mail, without unreasonable delay, but in no event later than 60 days after the breach is discovered or within such shorter time period specified under applicable state law. The 60-day period will be measured as of the first day on which the Breach is known, or by exercising reasonable diligence should have been known to an Aetna Workforce Member (other than the person committing the Breach) or to a Business Associate of Aetna that is an Agent of Aetna (as determined under Federal common law of an agency.) There were no breaches of unsecured PHI during this time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach.	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period **Evidence as Submitted by the MCE:** • S2R17 Breach Notification Letter Template with Reading Level	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address. 45 CFR §164.404(c) 45 CFR §164.406(c) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• SR17 Corp Breach Notification Policy, pgs 5-6, Section 9, pg 7, Section 13.	
MCE Description of Process: The contents of the notification will be written in plain language and will include, to the extent possible: A brief description of what happened, including the date of the Breach and the date of discovery of the Breach; if known; A description of the types of unsecured PHI/ePHI and/or PII that were involved in the Breach such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved); any steps individuals should take to protect themselves from potential harm resulting from the Breach; A brief description of what Aetna is doing to investigate the Breach, to mitigate harm to individuals, and to protect against further Breaches; Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address; and Any additional information required by applicable state law. There were no breaches of unsecured PHI during this time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The notification must be provided in the following form: a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual	**HSAG Required Evidence:** • Policies and procedures • Confirmation of first-class mailing	☒ Met ☐ Not Met

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Evidence as Submitted by the MCE:** • S2R18 Corp Breach Notification Policy, pg 6, Section 10.	☐ NA
MCE Description of Process: ABH will notify affected individuals by first-class mail, without unreasonable delay, but in no event later than 60 days after the Breach is discovered or within such shorter time period specified under applicable state law. If Aetna knows the impacted individual is deceased and has the address of the next of kin or Personal Representative of the individual, it will provide written notification by first-class mail to either the next of kin or Personal Representative of the individual. The notification may be provided in one or more mailings as information is available. Selection of first class for mailing would occur during the coordination of print and mail. Either through the one-off mailing portal or when coordinating with a print vendor for a large volume breach.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided. a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be	**HSAG Required Evidence:** • Policies and procedures • One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
provided by an alternative form of written notice, telephone, or other means. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE's website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may be included in the breach. c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period **Evidence as Submitted by the MCE:** • S2R19 Corp Breach Notification Policy, pgs. 6-7, Section 11.	
MCE Description of Process: Subject to any additional requirements under applicable state law: a. If Aetna has insufficient or out-of-date contact information that precludes written notification to the individual, it will provide a substitute form of notice reasonably calculated to reach the individual. b. Substitute notice will not be provided to next of kin or Personal Representatives (if available) of the individual in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or Personal Representative. c. If there is insufficient or out-of-date contact information for fewer than ten (10) individuals, then the substitute notice may be provided by an		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
alternative form of written notice, telephone, or other means. A toll-free phone number is not required. d. If there is insufficient or out-of-date contact information for ten (10) or more individuals, then the substitute notice will: i. be provided in the form of either a conspicuous posting for a period of 90 days on the home page of the Aetna website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the Breach likely reside; and ii. include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI/ePHI and/or PII may be included in the Breach. Substitute notice template/script was not applicable during this review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period **Evidence as Submitted by the MCE:** • S2R20 Corp Breach Notification Policy, pg. 7, Section 12.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Privacy Office will make a determination whether an Incident requires urgency because of the possible imminent misuse of unsecured PHI/ePHI and/or PII and, if so, it will provide notification by telephone or other appropriate means available. An urgent situation requiring urgent notification was not applicable during this review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. 45 CFR §164.404(c) 45 CFR §164.406(a-b) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period **Evidence as Submitted by the MCE:** • S2R21 Corporate Breach Notification Policy, pg. 7, Section 13.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: If the Breach involves the unsecured PHI/ePHI of more than 500 residents of a state or jurisdiction, or as required by applicable state law, Aetna will notify prominent media outlets serving the state or jurisdiction of the Breach within the same time frames and providing the same information as would be provided directly to the individual or as otherwise required by applicable state law. A breach impacting more than 500 members was not applicable during this review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary. a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members • Annual notification to HHS of breaches of unsecured PHI, including the date of notification	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Department of Health and Human Services (HHS) Web site. b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site. 45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Evidence as Submitted by the MCE:** • S2R22 Corporate Breach Notification Policy, pg. 7, Section 14b • S2R22 HHS Breach Porting Reporting Template • S2R22 Risk Assessment and Breach Tracking Tool.	
MCE Description of Process: For Breaches of unsecured PHI/ePHI made by CVS Health or a Business Associates of CVS Health, included Aetna, involving 500 or more individuals, regardless of their state or states of residence, CVS Health will provide notification of the Breach without unreasonable delay, and in no event later than 60 days following the discovery of the Breach, to HHS with the notice provided to the affected individuals and in the manner specified on the HHS website. For Breaches of unsecured PHI/ePHI made by CVS Health or a Business Associate of CVS Health involving fewer than 500 individuals, the Privacy Office will maintain a log or other documentation of the Breaches and, not later than 60 days after the end of each calendar year, provide notification to HHS for Breaches occurring during the preceding calendar year, in the manner specified on the HHS website. There were no breaches of unsecured PHI during this time period. If there were the annual notification provided to HHS would happen here via their portal: https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach. a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate. b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available. 45 CFR §164.404(c)	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract **Evidence as Submitted by the MCE:** • S2R23 Contracting Requirements, pg. 2, Section 1 d • S2R23 Corp Breach Notification Policy, pg. 2, Section 1 • S2R23 Business Associate Agreement template, pg. 2, Section g • S2R5 – ABHLA—HFI—RCA – subcontractor contract	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.410 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: ABH requires all subcontractors and business associates to report any known unauthorized use, disclosure, or breach of unsecured PHI without unreasonable delay, in accordance with the terms outlined in the applicable agreement, regulatory compliance addendum, or contract. There were no breaches of unsecured PHI reported during this review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Privacy Practices		
24. The MCE's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member's rights and the MCE's legal duties with respect to PHI. a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1). b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Process for disseminating Notice of Privacy Practices • Staff training materials • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the MCE's website **Evidence as Submitted by the MCE:** • S2R24 Notice of Privacy Practices • S2R24 Notice and Transparency, pg 2, Sections IV-V, pgs 3-4, Section III 1 • S2R24 – 2024 Member Handbook, pgs. 18, 49, 51	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Each notice will be written in plain language so the average reader can understand the notice. The notice must contain the elements required. ABH will make its notice available to anyone upon request. Link to the Notice of Privacy Practice on website: https://www.aetnabetterhealth.com/louisiana/footers/privacy.html		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	24	X	1	=	24
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	24	**Total Score**		=	24

Total Score ÷ Total Applicable	=	**100%**

Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	**Required Components**	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pgs. 2, 5, 11, 12, 19, 21, 23, 50, 91, 95-97, 99	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220 MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 MCO Contract: 2.9.32. 1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526 MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9		
42 CFR §438.100(b)(3) 42 CFR §438.206 through§438.210 42 CFR §457.1220 MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 18	Y ☒ N ☐ NA ☐
42 CFR §438.100(c) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.15	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member. **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook – pg. 19	Y ☒ N ☐ NA ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III	9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA). **Evidence as submitted by the MCE:** • S2AR – 2024 Member Handbook, pg. 99	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1		

Standard III—Member Information

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Information Requirements		
1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. *"Readily accessible" means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.* *Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.* 42 CFR §438.10(c)(1) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) **Evidence as Submitted by the MCE:** • S3R1-A-LA 4600.21 Member Materials Standards, pg. 2. • S3R1-2024 Member Handbook • S3R1-ABHLA Website Readability Report-Grade Level • S3R1_A-LA 3000.09 Beneficiary Nondiscrimination policy, pg 2-3 • S3R1 – Website Accessibility Report	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABHLA provides all required information in English and Spanish, complying with the state's requirement that all member-facing materials are written at no more than a 6.9 grade reading level.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE uses the definitions for managed care terminology developed by the State including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S3R2-2024 Member Handbook, pg. 88.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The state contract is not written at the appropriate grade level for members, therefore our definitions in the Member Handbook Glossary differ slightly from the contract, so that they are at the appropriate reading level for enrollees.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
3. The MCE uses State-developed model member handbooks and member notices. PIHP: a. *The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.* 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) **Evidence as Submitted by the MCE:** • S3R3-LDH Approval of Member Handbook 2024 • S3R3 Approval of G&A Letter Update 2024 • S3R2 – 2024 Member Handbook • S3R4_ABD Notice Example • S3R4_MCD_LA03 LA Medicaid OP Denial Full	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: LDH does not provide a model member handbook; however, ABH submits its member handbooks for state review and it was approved for use.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Language and Format		
4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas.	**HSAG Required Evidence:** • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15	• Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials **Evidence as Submitted by the MCE:** • S3R4-2024 Member Handbook, pg. 98. • S3R4-A-LA 4600.21 Member Materials Standards, pg. 3. • S3R4 - Appeal Upheld letter_Redacted • S3R4 - Grievance Resolution letter_Redacted • S3R4_MCD_LA03 LA Medicaid OP Denial Full • S3R4_ABD Notice example • S3R4 – Online Provider Directory – Spanish • S3R4 - Member Handbook (Spanish)	
MCE Description of Process: ABHLA makes its written materials available in English and non-prevalent languages found in taglines across materials. The online Provider Directory can be adjusted to be viewed in Spanish, demonstrated by the attached screenshot. Printed directories are available in Spanish upon request.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The written materials critical to obtaining services did not meet criteria related to taglines, request for auxiliary aids and services at no cost, and the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number.		
Required Actions: The MCE must make sure written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.		
5. The MCE makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. 42 CFR §438.10(d)(4) 42 CFR §457.1207 MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the MCE:** • S3R5-A-LA 4600.21 Member Materials Standards, pg. 3. • S3R5 - Interpretation Services Oral - Signed_Akorbi, LLC Master Translation SOW 2024-2027	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3R5 - Interpretation Services Written - Signed_Language Line Services, Inc Master SOW 2024-2027 • S3R5– A-LA 4500.25 Interpreter and Translation Services • S3R5 - Desktop for 4500.25 Interpreter and Translation Services	
MCE Description of Process: Members can obtain interpreter services by contacting Aetna Better Health's Member Services. Interpreter and translation services are available at no cost and include oral interpretation and written materials in alternative formats like large print, audio, or Braille. Members are informed of these services within 30 days of enrollment, after significant material changes, and annually. Details are also provided in the Member Handbook, welcome letters, newsletters, and on the Aetna Better Health website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S3R6-2024 Member Handbook, pgs. 2, 5, 12, 19, 37, 74, 75, 79, and 99. • S3R5 – A-LA 4500.25 Interpreter and Translation Services	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA informs members that oral interpretation services are available for any language and written translations are provided in prevalent languages, free of charge. Members are also notified that auxiliary aids and services, such as large print, Braille, audio formats, and sign language interpreters, are available at no cost for individuals with disabilities. To access these services, members can call Member Services at 18552420802 (TTY: 711), available 24/7. Information about these services is included in the Member Handbook, welcome materials, and on the plan's website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. *"Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.* 42 CFR §438.10(d)(6) 42 CFR §457.1207 MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Provider directory • All member newsletters during the time period of review • Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S3R7 - Grievance Resolution Letter template • S3R7 - Member Medical Appeal Denial template • S3R1-2024 Member Handbook • S3R5 – A-LA 4500.25 Interpreter and Translation Services (mechanism to assess Reading Grade Level) • S3R7 – Interpretation Services Report – QMOC 9.24.2024 • S3R7 - Provider Directory Website • S3R7 - ABH_LA_Summer2024 • S3R7 - ABH_LA_Spring2024_final_1.10.23 • S3R7 - ABH_LA_Fall2024_R2	
MCE Description of Process: ABHLA provides all written materials in a language, format, and reading grade level that is consistent with contract requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The written documents submitted as evidence were tested by the HSAG reviewer and resulted in a readability above the 6.9 grade reading level. Furthermore, ABH did not provide results of a reading grade level test that indicated member materials met the 6.9 grade read level.		
Required Actions: The MCE must provide all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Information for Members		
8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. PAHP: a. The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. 42 CFR §438.10(f)(1) 42 CFR §457.1207 MCO Contract: 2.13.9.2 PAHP Contract:2.6.11.4 PIHP Contract: 5.14.1.2	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members • Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Tracking or reporting mechanism that demonstrates timeliness **Evidence as Submitted by the MCE:** • S3R8- A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations • S3R8 – PCP Term Member Notification Process	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3R8 - Desktop Process for 4500.12D Member Move Requests_Louisiana • S3R8 - LA-(provider 1) • S3R8 - LA-(provider 2) • S3R8 - Member Moves Tracker Screenshot • S3R8 – Provider Term – Future Date – HealthTrackRX Termination 5-22-24 • S3R8 – Provider Term – Future Date – Access Health Louisiana 12-12-24 • S3R8 – Provider Term – Retro Date – DME Medical Supply Term 7-25-2024 • S3R8 – Provider Term – Retro Date – Sonoran Desert Pathology Associates Term 7-26-2024 **Additional Documentation:** • S3R8 LA Notification Member Letters • S3R8 - 4500.12D Member Move Requests Desktop	
MCE Description of Process: ABHLA makes a good faith effort to notify members in writing of a termed provider. Member Services utilizes a process for notification of members. Member moves are tracked in a Quickbase system utilized by the Member Moves team.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not support that ABH made a good faith effort to give written notice, within required time frames, of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The member notification letters submitted as evidence were dated six months following the effective date of the provider termination.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must ensure it makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice.		
9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • S3R9 - 0013 ABHLA 2024 SA1 • S3R16-17 -2024 Member Handbook – pg. 71 • S3R9 - A-LA 1400.04 Value Based Solutions Pay for Quality Program • S3R9 - Sample PIP from 2024 LCMC	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Semi-Annual 0013 report is provided to LDH twice per year. The right of a member to request information on Physician Incentive Plans or how providers are paid, is provided in the 2024 Member Handbook. ABHLA did not receive a request from a member for PIP in 2024.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Member Handbook		
10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the MCE's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. PAHP: a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled: i. A current enrollee handbook 42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) • Member materials, such as member welcome packet • Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member **Evidence as Submitted by the MCE:** • S3R10 – Member Materials Online • S3R1- A-LA 4600.21 Member Materials Standards, pg. 2. • S3R10 - A-LA 4500.15 New Existing and Reinstated Member Information • S3R10 – Welcome Kit Envelope • S3R10 – Welcome Kit HNA English • S3R10 – Welcome Kit HNA Spanish • S3R10 – Welcome Kit Letter • S3R10 – Welcome Kit Newsletter • S3R10 – Aetna Fulfillment Report (report from printing vendor of member mailings)	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.13.6.3 PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2 PIHP Contract: 5.8.3.3		
MCE Description of Process: ABHLA ensures that new members receive the Member Handbook within ten business days of enrollment, either by mailing a printed copy or providing electronic access based on member preference. The handbook is available online, and members are provided with the website address, along with instructions for requesting alternative formats such as large print, audio, or Braille at no cost. The handbook is also distributed annually to new members and to any member upon request. All member-facing materials are written at an accessible reading level and sent to the state for approval prior to distribution.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on MCE's website • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the MCE:** • https://www.aetnabetterhealth.com/louisiana/member-materials-forms.html • S3R1-2024 Member Handbook **Additional Documentation:** • S3R11-2024 Member Handbook, pg. 44-50 • S3R11_2024 BH Member Handbook, pgs. 22-26 • S3R11_2024 BH Member Handbook, entire document	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA includes all requirements listed in the Member Handbook Checklist.		
HSAG Findings: HSAG has determined that the MCE met the requirement for this element.		
Required Actions: No action required.		
12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change. *Note: LA defines significant as "important in effect or meaning."* 42 CFR §438.10(g) 42 CFR §457.1207 MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the *MCE Description of Process*) • Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified **Evidence as Submitted by the MCE:** • S3R1- A-LA 4600.21 Member Materials Standards, pg. 2.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: There were no significant changes made to the Member Handbook during CY2024.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Provider Directory		
13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) • Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the MCE:** • S3R13- A-LA 6300.20 Provider Directory Updates • S3R13 - A-LA 4500.21D Requests for Printed Member Materials	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: ABHLA makes the provider directory available in paper form at the member's request. Paper directories are not automatically mailed. The Provider Directory can be found at Link on Member Website: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pdfs/provider-directories/Vol1%20Aetna%20LA02%20Accessible%20PaperDirectory.pdf		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's paper provider directory did not include the following components: • Website Uniform Resource Locator (URL). • Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCE ensure its public, searchable provider directory is updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: The MCE must include the following components in the paper provider directory: • Website URL. • Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.		
14. Information included in the MCE's paper provider directory is updated at least: a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCE has a mobile-enabled electronic provider directory. PAHP: a. *The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.* 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3	**HSAG Required Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Three consecutive provider directory update examples, including the dates for when the updates were made **Evidence as Submitted by the MCE:** • Link on Member Website: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pdfs/provider-directories/Vol1%20Aetna%20LA02%20Accessible%20PaperDirectory.pdf • S3R10 – Member Materials Online • S3R14- A-LA 6300.20 Provider Directory Updates • S3R13 - A-LA 4500.21D Requests for Printed Member Materials • S3R14 - Mobile Provider Directory Image	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3R14-15 – Paper Provider Directory April - Aetna_LA02_Accessible_PaperDirectory 202504 • S3R14-15 – Paper Provider Directory May - Aetna_LA02_Accessible_PaperDirectory 202505 • S3R14-15 – Paper Provider Directory June - Aetna_LA02_Accessible_PaperDirectory 202506	
MCE Description of Process: ABHLA creates and maintain policies that will ensure adherence to contractual requirements for making provider directories available in paper format and electronically. Paper copies of the provider directory may be requested at any time. The directory is generated using a prompt in QNXT.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. Information included in the MCE's electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information. MCO: a. The web-based online version shall be updated in real time, but no less than weekly. PAHP: a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated provider information and the date the change was reflected in the electronic provider directory • Tracking mechanisms to demonstrate timeliness **Evidence as Submitted by the MCE:** • S3R15- A-LA 6300.20 Provider Directory Updates • Link on Member Website: https://www.aetnabetterhealth.com/content/dam/a	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3	etna/medicaid/pdfs/provider-directories/Vol1%20Aetna%20LA02%20Accessible%20PaperDirectory.pdf • S3R15 - HSAG Directory • S3R15 - FW LA Network Adequacy Project Case Number 127202717 • S3R15 - PRMS Case# 127202717 - Request has been completed • S3R14-15 – Paper Provider Directory April - Aetna_LA02_Accessible_PaperDirectory 202504 • S3R14-15 – Paper Provider Directory May - Aetna_LA02_Accessible_PaperDirectory 202505 • S3R14-15 – Paper Provider Directory June - Aetna_LA02_Accessible_PaperDirectory 202506	
MCE Description of Process: ABHLA receives corrected provider information from the provider and forwards them to the Medicaid Provider Operations Support team (MPOS) for system updates. A case number is issued, which allows tracking of the status of the request. Confirmation is sent via email by MPOS to confirm that the case has been successfully closed and that provider information has been updated.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. The MCE's provider directory is made available on the MCE's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 MCO Contract: 2.13.8.1.2	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the publicly available machine-readable provider directory on the MCE's website	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1	**Evidence as Submitted by the MCE:** • S3R16-17 - 2024 Member Handbook, pg. 53-54	
MCE Description of Process: ABHLA makes the provider directory available on its website, viewable on mobile. ABHLA is currently developing its machine-readable file		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element ABH's provider directory was not available on the MCE's website in a machine-readable file and format as specified by the Secretary. During the virtual interview, ABH's staff members stated that they were in the process of developing a machine-readable file to be made available on the MCE's website.		
Required Actions: The MCE must have a provider directory available on the MCE's website in a machine-readable file and format as specified by the Secretary.		
Formulary		
17. The MCE makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the publicly available formulary on the MCE's website **Evidence as Submitted by the MCE:** • S3R10 – Member Materials Online • S3R17 – Provider and Pharmacy Directory • S3R17 – PDL • S3R17_Magellan Pharmacy MCO Agreement 10-17-23 • S3R16-17 - 2024 Member Handbook, pg. 53-54 • S3R17 - A-LA 7600.10 Formulary	☐ Met ☐ Not Met ☒ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf (link to Formulary) • S3R17 – ABHLA Member Web Link to Formulary (Screenshot)	
MCE Description of Process: Prime Therapeutics, as single PBM for Louisiana Medicaid, maintains the most current version of these records for CY 2024. Members are provided with a pharmacy directory included in the provider directory, and links to covered medications via the formulary.		
HSAG Findings: The State contracted with a single Pharmacy Benefits Manager (PBM) for the Louisiana Medicaid managed care program. Therefore, HSAG has determined that this requirement is not applicable. However, the MCE did provide a link on its website to a formulary that the single PBM maintained.		
Required Actions: No action required.		
18. The MCE's formulary drug list is made available on the MCE's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(3) 42 CFR §457.1207 MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable formulary (e.g., .JSON format) • Link to the publicly available machine-readable formulary on the MCE's website **Evidence as Submitted by the MCE:** • S3R17 – PDL • S3R17 - A-LA 7600.10 Formulary • https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf (link to Formulary) • S3R17 – ABHLA Member Web Link to Formulary (Screenshot) • S3R10 – Member Materials Online	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The formulary is made available on the website. Prime Therapeutics, as single PBM for Louisiana Medicaid, maintains the most current version of these records in CY2024. Members are provided with a pharmacy directory included in the provider directory, and links to covered medications via the formulary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Electronic Materials and Communications		
19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the MCE's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7	**HSAG Required Evidence:** • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE's homepage of its website • Tracking mechanisms related to requests for information in paper form that includes the date of the member's request and the date it was provided to the member (e.g., mailed) • Evidence for how members are informed that paper copies of information are available upon request and without charge **Evidence as Submitted by the MCE:** • S3R1- A-LA 4600.21 Member Materials Standards • S3R10 – Member Materials Online • https://www.aetnabetterhealth.com/louisiana/index.html	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3R1 – 2024 Member Handbook, pg. 23 **Additional Documentation:** • https://www.aetnabetterhealth.com/louisiana/notice-of-non-discrimination.html - "Provides free aids and services to people with disabilities to communicate effectively with us"	
MCE Description of Process: ABHLA follows the requirements set out in the LDH MCE Marketing and Member Education Companion Guide.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days.		
Required Actions: The MCE must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days.		

Results for Standard III—Member Information							
Total	Met	=	12	X	1	=	12
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	18	**Total Score**		=	12

Total Score ÷ Total Applicable	=	**67%**

Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE. **Evidence as submitted by the MCE:** • Pgs. 24-42 • Pgs. 35-41 (VABs) • Pgs. 44-56 (50-54 are dental, pharmacy, pregnancy care)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State. **Evidence as submitted by the MCE:** • Pgs. 2-4 • Pgs. 8-11 • Pgs. 41-42	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided. **Evidence as submitted by the MCE:** • Pg. 3 • Pgs. 24-25 • Pg. 40	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.16	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE.	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	**Evidence as submitted by the MCE:** • NA, ABHLA follows the state fee schedule and does not deny coverage based on moral or religious grounds	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections. **Evidence as submitted by the MCE:** • NA, ABHLA follows the state fee schedule and does not deny coverage based on moral or religious grounds. Member is informed of right to disenroll if this happens, on pg. 79-80	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. *For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.* **Evidence as submitted by the MCE:** • Pgs. 26-42 (general amount, duration & scope of benefits), • Pg. 2 (specialized BH) • Pg. 38 (tobacco cessation) • Pg. 50 (problem gambling) • Pgs. 44, 59-61 (case management)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. *The PIHP must also include procedures for plan of care development.*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PIHP Contract: 5.9.2.11	**Evidence as submitted by the MCE:** • Member Services Contact information on the footer of each page. • Pgs. 2-4 • Pgs. 22-25 (authorizations) • Pgs. 42-43 (obtaining authorizations) • Pgs. 59-60 (referrals from Case Management) • Pgs. 67-68 (for obtaining benefits) • Pg. 67 (self-referral)	
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the MCE:** • Pg. 61-68 (emergency care) • Pg. 63 (24 hour nurse line) • Pgs. 67-68 (after-hours care specifics)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the MCE:** • Pg. 65 (Emergency) • Pg. 88 (Glossary definition of Emergency, Emergency Medical Condition, Emergency Dental Condition, Emergency Room Care, Emergency Services)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the MCE:** • Pg. 17 • Pg. 29 (prior auth not required in table listing Emergency medical services) • Pg. 43	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the MCE:** • Pg. 44 (BH Emergency) • Pgs. 61-62 • Pg. 65	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the MCE:** • NA, members are not restricted within the network	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.10 PAHP Contract: 2.9.7.2 PIHP Contract: None	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider. **Evidence as submitted by the MCE:** • Pg. 42 • Pgs. 52-53 • Pg. 68 (Urgent Care)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan). **Evidence as submitted by the MCE:** • NA for covered services, pg. 42 • Pharmacy costs, Pgs. 51-52	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. **Evidence as submitted by the MCE:** • Pg. 16	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member's primary care provider/primacy dental provider. **Evidence as submitted by the MCE:** • Pgs. 20-21	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	17. The right to file grievances and appeals. **Evidence as submitted by the MCE:** • Pgs. 72-79	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal. **Evidence as submitted by the MCE:** • Pgs. 72-79	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	19. The availability of assistance in the filing process for grievances and appeals. **Evidence as submitted by the MCE:** • Pg. 72	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	20. The right to request a state fair hearing (SFH) (or a State external review for the Children's Health Insurance Program [CHIP]) after the MCE has made a determination on a member's appeal which is adverse to the member. **Evidence as submitted by the MCE:** • Pg. 74 • Pg. 76	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member. **Evidence as submitted by the MCE:** • Pg. 76	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) *The MCOs must provide a description of advance directives which includes:* *The MCO's policies related to advance directives;* *The enrollee's rights under State Law, including the to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;* *Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and* *Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • Pgs. 80-82	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5; 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. *For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.* *For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.*	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Pg. 10 • Pg. 98	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Helpful Information section – pg. 2 of the Member Handbook document (not a numbered page) • Each page of Member Handbook has Member Services contact information on footer • Pgs. 2-4 (Important Numbers)	
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse.	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Pg. 3 • Pg. 78	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. *The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.* **Evidence as submitted by the MCE:** • Pgs. 15-16	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	27. *The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;* **Evidence as submitted by the MCE:** • Pg. 2 • Pgs. 11-12 • Pgs. 14-15 • Pg. 71	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. *The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";* **Evidence as submitted by the MCE:** • Pgs. 22-23 • Pg. 64	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.28 PAHP Contract: NA	29. *The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PIHP Contract: NA	**Evidence as submitted by the MCE:** • Pgs. 71-72	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	30. *The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;* **Evidence as submitted by the MCE:** • Pgs. 71-72	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. *The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;* **Evidence as submitted by the MCE:** • Pg. 18 • Pg. 80 (misuse of card)	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. *The MCOs must include the date of the last revision;* **Evidence as submitted by the MCE:** • Front cover of 2024 Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	33. *The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:* a. *A description of covered behavioral health services;* b. *Where and how to access behavioral health services and behavioral health providers;* c. *General information on the treatment of behavioral health conditions*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; d. *Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and* e. *Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.*	
	Evidence as submitted by the MCE: • Pg. 2 (BH Crisis line) • Pg. 4 (Specialized BH Services number) • Pgs. 44-50 (Specialized BH section)	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	34. *The PIHP must include CSoC eligibility requirements;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	35. *The PIHP must include Member's Bill of Rights;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	36. *The PIHP must include where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	37. *The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a "no-show;"* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. *The PIHP must include family's/caregiver's or legal guardian's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. *The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult's engagement, resilience, strength-based and evidence-based practice, and best/proven practices;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. *The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. *The PIHP must include any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. *The PIHP must include how to identify and contact the WAAs and FSO;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. *The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. *The PIHP must include the date of the last revision;* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. *The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and* **Evidence as submitted by the MCE:** • NA	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. *The PIHP must include additional information that is available upon request, including the following:* a. *Information on the structure and operation of the Contractor;* b. *Pharmacy location or medication information availability;* c. *Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and* d. *Service utilization policies*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA	

Provider Directory Checklist

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider's name as well as any group affiliation. **Evidence as submitted by the MCE:** • See S2BR1- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es). **Evidence as submitted by the MCE:** • See S2BR2- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s). **Evidence as submitted by the MCE:** • See S2BR3- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207	4. Website Uniform Resource Locater (URL), as appropriate. **Evidence as submitted by the MCE:** • S2R4- Directory Screenshot – web directory has a space to accommodate URLs if provided	Y ☐ N ☒ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1		
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate. **Evidence as submitted by the MCE:** • See S2BR5- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members. **Evidence as submitted by the MCE:** • See S2R6- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. **Evidence as submitted by the MCE:** • See S2BR7- Directory Screenshot	Y ☐ N ☒ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. **Evidence as submitted by the MCE:** • See S2BR8- Directory Screenshot	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; The MCO provider directory components are included for the following provider types *and shall be delineated by parish and zip code*: a. *Hospital primary care physician (PCP) groups* b. *Clinic settings* c. *Home and community-based services* d. *Outpatient therapy* e. *Residential substance use* f. *Youth residential services* g. *Inpatient mental health and residential substance use services* h. *Federally qualified health centers (FQHCs)* i. *Rural health clinics (RHCs)* j. *Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.* k. *Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.* l. *Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.*	Y ☒ N ☐ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
	The PAHP provider directory components are included for the following provider types: a. *Endodontists* b. *Maxillofacial surgeons* c. *Oral surgeons* d. *Orthodontists* e. *Pedodontists* f. *Periodontists* g. *Prosthodontists* h. *Special needs pedodontists*	
	Evidence as submitted by the MCE: • S2BR9A-D- Directory Screenshot Physicians • S2BR9A-D- Directory Screenshot Specialists • S2BR9A-D- Directory Screenshot Hospital • S2BR9A-D- Directory Screenshot Pharmacy • S2BR9A-D- Directory Screenshot Behavorial Health • S2BR9A- Directory Screenshot • S2BR9A2- Directory Screenshot • S2BR9B- Directory Screenshot • S2BR9C- Directory Screenshot • S2BR9D- Directory Screenshot • S2BR9E- Directory Screenshot • S2BR9F- Directory Screenshot • S2BR9G- Directory Screenshot • S2BR9I- Directory Screenshot • S2BR9K- Directory Screenshot • S2BR9L- Directory Screenshot	

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	10. *The PAHP provider directory must include the following:* a. *The provider's cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;* b. *Office hours;* c. *Specific performance indicators;* d. *A statement that some providers may choose not to perform certain services based on religious or moral beliefs;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA for MCO.	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. *The PAHP Provider Directory must also include the following:* a. *Providers arranged by name in alphabetical order* b. *Showing the provider's specialty,* c. *Providers listed by specialty in alphabetical order by name.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA for MCO.	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. *The PIHP Provider Directory must include the following:* a. *Indication of populations served by the provider (e.g., age range of clients) and specialties;* b. *Identification of any restrictions on the member's freedom of choice among providers;* c. *Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours);* d. *Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA for MCO.	

Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The MCE defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_NCS_527 Emergency Services and Call Handling, pg 1-2 • S4_2024 UM Program Description, pg 22-23 • S4_2024 Member Handbook, pg 61-62, 65, & 88 • S4_2024 ABHLA Provider Manual, pg 92-93	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE defines "emergency services" as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_2024 UM Program Description, pg 22-23 • S4_2024 Member Handbook, pg 61-62, 65, & 88 • S4_2024 ABHLA Provider Manual, pg 91-92 & 124 • S4_2024 Prior Authorization Policy, pg 3 **Additional Documentation:** • S4-S6 - ABH LA Facility Contract Packet 1, pg. 25. • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE defines "post-stabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook	☒ Met ☐ Not Met

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary	• Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_2024 UM Program Description, pg 22-23 • S4_2024 Member Handbook, pg 66 • S4_2024 ABHLA Provider Manual, pg 91 & 124 • S4_2024 Prior Authorization Policy, pg 3 **Additional Documentation:** • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	☐ NA
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment		
4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)	
	Evidence as Submitted by the MCE: • S4_2024 UM Program Description, pg 22-23 • S4_2024 Member Handbook, pg 61-62 • S4_2024 ABHLA Provider Manual, pg 92 & 124 • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20 • S4_ER claim examples • S4_2024 Prior Authorization Policy, pg. 3 **Additional Documentation:** • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
medical attention would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the MCE instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1	• Claim payment algorithm for emergency services • Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_2024 UM Program Description, pgs. 22-23 • S4_2024 Member Handbook, pg. 61-62 • S4_2024 ABHLA Provider Manual, pg. 92 & 124 • S4_NCS_527 Emergency Services and Call Handling Policy & Procedure, pg. 3-10 • S4_ER claim examples • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pgs. 18-20	
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Additional Rules for Emergency Services		
6. The MCE does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCE, or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1) 42 CFR §457.1228 MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_2024 UM Program Description, pg 22-23 • S4_2024 Member Handbook, pg 61-62 • S4_2024 ABHLA Provider Manual, pg 124 • S4_ER claim examples • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20 • S4_2024 Prior Authorization Policy, pg 3 **Additional Documentation:** • S4-S6 - ABH LA Facility Contract Packet 1, pg. 25. • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024, pg. 3	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_2024 Member Handbook, pg 61-62 • S4_2024 ABHLA Provider Manual, pg 50 • S4_2024 UM Program Description, pg 22-23 • S4_ER claim examples • S4_Post-stabilization claim examples • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
provider actually treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Aetna Better Health does not impose cost-sharing obligations and must ensure that Members are not billed for any amounts billed by the out-of-network provider and not paid by the health plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE. 42 CFR §438.114(d)(3) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services **Evidence as Submitted by the MCE:** • Case examples will not be available as no prior authorization is required for emergency services. • S4_2024 ABHLA Provider Manual, pg 92 • S4_2024 Member Handbook, pg 65 • S4_2024 UM Program Description, pg 22-23 • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20 • S4_2024 Prior Authorization Policy, pg 3 **Additional Documentation:** • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The health plan provides coverage of emergency and post-stabilization services for the treatment of an emergency medical or behavioral health condition from network providers or out-of-network providers at any time without need for a referral or service authorization. Therefore, ABHLA will not have P2P examples for these services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment of Poststabilization Care Services		
9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative. 42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for post stabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_2024 ABHLA Provider Manual, pg 91, 109, & 125 • S4_Post-stabilization claim examples • S4_NCS 300- Retrospective Review Procedure 2024, entire document • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20 • S4_2024 Prior Authorization Policy, pg 3	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member's stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.1 PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services **Evidence as Submitted by the MCE:** • S4_2024 ABHLA Provider Manual, pg 92, 109, & 124 • S4_2024 UM Program Description, pg 22-23 • S4_NCS 300- Retrospective Review Procedure 2024 • S4_A-LA 2000.25 Claims Adjudication Policy_2024 Review, pg 18-20 • S4_2024 Prior Authorization Policy, pg 3	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if: a. The MCE does not respond to a request for pre-approval within one hour. b. The MCE cannot be contacted. c. The MCE representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services • Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE's response • One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services **Evidence as Submitted by the MCE:** • S4_2024 ABHLA Provider Manual, pg 50, 91, 108, & 124 • S4_2024 UM Program Description, pg 22-23 • S4R11_ MedCompass UM Task Timeliness and Aging Report	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1	• S4R11_MedCompass UM Turnaround Time Management Report • S4_Post-stabilization claim examples • S4_NCS 300- Retrospective Review Procedure 2024 • S4R11_P2P case example	
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow for claims review process for poststabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_2024 ABHLA Provider Manual, pg 41, 91, 124, 143 • S4_2024 Member Handbook, pg 61-62	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• S4_2024 UM Program Description, pg 22-23 • S4_Post-stabilization claim examples • S4_Retrospective Claim Review Process • S4_NCS 300- Retrospective Review Procedure 2024	
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Aetna Better Health does not impose cost-sharing obligations and must ensure that Members are not billed for any amounts billed by the out-of-network provider and not paid by the health plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
End of the MCE's Financial Responsibility		
13. The MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_2024 ABHLA Provider Manual, pg 50, 92, 108, & 124 • S4_2024 Member Handbook, pg 65 • S4_2024 UM Program Description, pg 22-23 • S4_2024 Prior Authorization Policy, pg 3	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1	**Additional Documentation:** • S4_AMA 7100.05 Prior Authorization Policy_04.13.2024	
MCE Description of Process: Aetna Better Health will pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider treating the member. This will include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IV—Emergency and Poststabilization Services							
Total	Met	=	13	X	1	=	13
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	13	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**100%**

Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1	**HSAG Required Evidence:** • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) **Evidence as Submitted by the MCE:** • S5R1 – A-LA 6400.41 Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan • S5R1 – ABHLA 2024 Population Health Assessment - • S5R1 – ABHLA 2025 Network Adequacy Analysis • S5R1 - 2024 ABHLA Provider Manual • S5R1 – ABHLA Ancillary Provider Contract Example • S5R1 – ABHLA Hospital Provider Contract Example	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5R1 – ABHLA Group Provider Contract Example **Additional Documentation:** • S5R1 – ABHLA Provider Group Contract Example, Page 38, Section 4.1 • S5R12 – ABHLA Data Long Form Roster Template	
MCE Description of Process: Aetna Better Health of Louisiana measures compliance with network practitioner accessibility and availability to ensure members have adequate access to available providers and practitioners. Network adequacy results are based on evaluation of adequacy of meeting member cultural/racial/ethnic/linguistic needs, availability of practitioners, accessibility to services, and member experience. Annual results are compared to established goals to determine if adequate availability and access is present, or if opportunities for improvement exist. Any barriers that exist to meeting goals will be identified if present. Improvement interventions will be implemented to counteract barriers or address deficiencies.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan, effective February 1, 2025, reviewed December 2024, outlined ABH's intent to comply with the requirement. ABH's Population Health (January–December 2023) and Network Adequacy Analysis (January 2024–December 2024; Report date: March 2025) demonstrated how ABH monitored its network, ensuring it had appropriate providers sufficient to provide adequate access to all services covered under the contract for all members, but these assessments failed to include efforts related to members with limited English proficiency and physical or mental disabilities. ABH's Provider Manual stated that providers must "deliver services in a culturally effective manner to all members, including: Those with limited English proficiency (LEP) or reading skills … and Individuals with physical and mental disabilities." ABH's Provider Manual also stated in the "Individuals with Disabilities" section that "[r]egular provider office [visits] will be conducted by our Provider Experience staff to verify that network providers are compliant" by ensuring provider offices are accessible to persons with disabilities. ABH's provider contracts also required providers to "provide physical access for Members with disabilities." During the interview, ABH staff members stated that ABH monitors accessibility to persons with disabilities during credentialing and subsequently provided its Data Long Form Template, which included an area for ABH to collect accessibility data. ABH did not provide any evidence of monitoring, through analysis of accessibility data, as required in 42 CFR 438.206(b)(1) and State contract requirements.		
Required Actions: The MCE must monitor, through the collection and analysis of data, its provider network to ensure access to all services for all members, including those with limited English proficiency or physical or mental disabilities.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines **Evidence as Submitted by the MCE:** • S5R2 – A-LA 8300.20 Family Planning & Reproductive Health • S5R2 – 2024 Member Handbook – pgs. 55, 56, 68 • S5R2 - Prior Authorization Policy, pg. 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Female members are provided access to women's health specialists within the provider network for both routine and preventive services. This level of care is in addition to traditional primary care services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • List of provider types designated as family planning providers • Network adequacy analysis of family planning providers **Evidence as Submitted by the MCE:** • S5R3-A-LA 8300.20 (Family Planning / Reproductive Health) • S5R3-PCP & OBGYN Maps	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5R3_2024 Member Handbook, pages 29,67-68 • S5R3 - ABHLA Group Provider Contract Example	
MCE Description of Process: Per LDH Take-Charge Plus (Family Planning) Provider Manual, family planning providers may include *any Medicaid-enrolled provider* whose scope of practice permits the delivery of family planning-related services. While there are not specific family planning adequacy standards, ABHLA has a robust physical health provider network able to provide these services. Geomaps demonstrating adequate PCP & OBGYN coverage are attached in support. As outlined in the ABHLA Member Handbook and P&P 8300.20, members may also access family planning services from their out-of-network provider of choice without a referral or prior authorization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) 42 CFR §457.1230(a) MCO Contract: 2.13.6.2.32 PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5 PIHP Contract:7.2.8	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines **Evidence as Submitted by the MCE:** • S5R4 – 2024 Member Handbook, page 23 • S5R4 - ABHLA Provider Manual, page 47 • S5R4_AMA 7100.10 Elective Referrals Policy, pg 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health informs members and providers that the member is allowed to seek a secondary opinion from in-network providers or arranges for the member to obtain one outside the network at no cost to the member. Second opinion tracking is currently not required per the contract or the CFRs.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them. 42 CFR §438.206(b)(4) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • S5R5 – ABHLA 6400.06 (Practitioner and Provider Availability) • S5R5 – ABHLA Single Case Agreement Example 1 • S5R5 – ABHLA Single Case Agreement Example 2 • S5R5 – ABHLA Single Case Agreement Example 3 • S5R5 – 0220 ABH 2024 SA2 - Physical Health: State Regulatory Report 220 • S5R5 – 0220 ABH 2024 SA2 – Corresponding Physical Health Geo Mapping • S5R5 – 328 ABH 2024 Q4_RESUBMIT_2 - Behavioral Health: State Regulatory Report 328 with corresponding 348 Geo Mapping (see next piece of evidence) • S5R5 – ABHLA_348_Adequary_Maps_2024 Q4_RESUBMIT_2 – corresponding Geo Maps for the BH 328 report	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5R5 – 2024 Member Handbook, pg 22 • S5R2 - Prior Authorization Policy, pg 5 • S5R4-A-LA 4500.35 Member Rights and Responsibilities, pg 4 **Additional Documentation:** • S5R5 - 346 ABH 2024 Q1 (see tab 3 for SCA timeliness)	
MCE Description of Process: When ABHLA's provider network is unable to deliver medically necessary, covered services to a member, the plan ensures timely access by authorizing and reimbursing out-of-network providers for those services. Medical services for the treatment of an emergency condition may be delivered in or out of network without obtaining prior authorization. The plan's Network Management and Utilization Management teams monitor network adequacy and initiate contracting or single-case agreements with out-of-network providers as needed to maintain continuity of care. These services are covered at no additional cost to the member for as long as the network deficiency persists.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE requires out of network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. 42 CFR §438.206(b)(5) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines • Member materials, such as the member handbook • Provider materials, such as materials on the MCE's website **Evidence as Submitted by the MCE:** • S5R6 – ABHLA 6400.06 (Practitioner and Provider Availability)	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5R6- A-LA 6300.11 Out-Of-Network Provider Payments • S5R6 – ABHLA Single Case Agreement Example 1 • S5R6 – ABHLA Single Case Agreement Example 2 • S5R6 – ABHLA Single Case Agreement Example 3 • S5R6_2024 UM Program Description, pg 20 • S5R6 – 2024 Member Handbook, pg 42 • S5R6_2024 ABHLA Provider Manual, pg 46 • S5R6_Claims Submission Policy, entire document • S5R6_LA Claims Adjudication policy, entire document **Additional Documentation:** • S5R6 - A-LA 2000.20 Claims Submission Amendment _ 2024 Review • S5R6 - A-LA 2000.25 Claims Adjudication Policy _ 2024 Review • S11R2 - Claims Submission Corporate Policy	
MCO Description of Process: Aetna Better Health does not impose cost-sharing obligations and must ensure that Members are not billed for any amounts by the out-of-network provider. When ABH's provider network is unable to deliver medically necessary, covered services to a member, the plan ensures timely access by authorizing and reimbursing out-of-network providers for those services. Medical services for the treatment of an emergency condition may be delivered in or out of network without obtaining prior authorization. The plan's Network Management and Utilization Management teams monitor network adequacy and initiate contracting or single-case agreements with out-of-network providers as needed to maintain continuity of care. These services are covered at no additional cost to the member for as long as the network deficiency persists.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]		
Timely Access		
7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the MCE:** • S5R7-ABHLA Group Provider Contract Example, Exhibit A, Section 2.12, page 32 • S5R1 - 2024 ABHLA Provider Manual, pages 30-33 • S5R7 – A-LA 6400.41 Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan, page 6 • S5R7 – Access Standards Network Analysis	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna requires its contracted Providers to allow our Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a Member for prompt medical care in cases where there is a need for urgent care or Emergency Services. Provider is required to clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan, Provider Manual, and Medicaid Provider/Group Agreement required its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. ABH's access standards network analysis, also known as the 2025 Network Adequacy and Accessibility Analysis, covering the review period of January 1, through December 31, 2024, identified that ABH did not meet the appointment availability goals for several service types. Specifically, ABH did not achieve the appointment availability goals for the following appointment types: 1) primary care provider (PCP): non-urgent sick care (88.3 percent), preventative care (85.9 percent), and after-hours emergency instructions given by recording (57.5 percent); 2) obstetrician/gynecologist (OB/GYN): first trimester (88.3percent), second trimester (48.4 percent), third trimester (38.1 percent), and initial prenatal appointment—high risk (50.3 percent). ABH met or exceeded the appointment availability goals for the remaining appointment types for an overall appointment availability compliance rate of 69.6 percent. During the interview, ABH staff members stated that the requirement for meeting the appointment availability goals was regularly discussed in its joint operating committee as well as with the State. ABH staff members also mentioned that when a provider was not compliant with the appointment availability goals, it required an in-person meeting with the provider to educate the provider and distribute training materials, such as Appointment and Wait Time Handouts. Furthermore, ABH staff members reported that the MCE also conducted secret shopper surveys for its behavioral health providers' appointment availabilities.		
Required Actions: The MCE must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.		
8. The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • S5R1 – 2024 ABHLA Provider Manual, pages 30, 33, and 36 • S5R8-ABHLA Group Provider Contract Example, Exhibit A, Section 4.23, page 43 • S5R8 - Provider Directory Audit 2024	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna requires its contracted Providers to offer hours of operation that are no less than the hours of operation offered to commercial members or other Louisiana Medicaid programs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • S5R4 – 2024 ABHLA Provider Manual, pages 30, 36, 38, and 100 • S5R9-ABHLA Group Provider Contract Example, Exhibit A, Section 2.1, page 52 • S5R9 - Access Standards Network Analysis • S5R9 - Access Standards 2024 Report • S5R8 - Provider Directory Audit 2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna requires its contracted Providers to allow Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a Member for prompt medical care in cases where there is a need for urgent care or Emergency Services. Contracted Providers must clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The MCE monitors network providers regularly to determine compliance. b. The MCE takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Results of provider monitoring mechanisms • Audit or secret shopper results/reports • Three examples of corrective action taken when a provider fails to meet timely access standards **Evidence as Submitted by the MCE:** • S5R10 Access Standards 2024 Report • S5R1 – A-LA 6400.41 Assessment of Network Adequacy, Availability and Access to Care	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. Aetna monitors network providers regularly to determine compliance. Aetna takes corrective action if there is a failure to comply with a network provider. There were no CAPs issued during the review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Access and Cultural Considerations		
11. The MCE participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) MCO Contract: 2.4.1.11	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.1.2 PIHP Contract: 5.1.8	• Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence	
	Evidence as Submitted by the MCE: • S5R11 Provider Directory Screenshot • S5R11 Provider Directory Screenshot2 • S5R11 – ABHLA Staff HE Policy 1100.00AETAMA-081236 • S5R11 – ABHLA HE Provider Policy 1100.04_AETAMA-018237 • S5R11 – 2024 TPN Courses • S5R11 – 2024 ABH HE Courses • S5R11 – Final_LDH Health Equity Year-End Report 2024	
MCE Description of Process: ABHLA promotes culturally competent care by training staff and providers on cultural awareness, bias, and effective communication with members of diverse backgrounds, including those with limited English proficiency and disabilities. We provide interpretation services, translate key materials, and use demographic data to tailor services and reduce health disparities. ABHLA engages members and community partners to ensure outreach and care delivery is culturally and linguistically appropriate. ABHLA also monitors service quality and continuously improves practices to ensure equitable, inclusive care for all members regardless of race, ethnicity, language, disability, or sex.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Accessibility Considerations		
12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results **Evidence as Submitted by the MCE:** • S5R12 – ABHLA Data Long Form Roster Template (2024 template), Column BZ • S5R12 Site Review Survey • S5R12 ABHLA Grievance Site Visit Form • S5R12 – A-LA 6300.52 Office Assessments Policy • S5R1 - 2024 Provider Manual, pg. 54 • S5R12 – Directory Screenshot • S5R12 – Directory Screenshot Handicap Accessibility	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • S5R12 – ABHLA Data Long Form Roster Template	
MCE Description of Process: ABHLA verifies a provider's special need accommodations via our Data Long Form collected during provider enrollment. Also see 6300.52 re: provider office visits and corresponding office visit tool. This information is also assessed during site visits. Aetna Better Health of Louisiana ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for our members with physical or mental disabilities by conducting office and site assessments.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's Office Assessments Policy stated that it conducts site visits following the receipt of a member grievance/complaint or annually. ABH used the Practitioner Office Site Complaint & Grievance Assessment Audit Tool or the Practitioner Office Site Assessment Audit Tool. ABH's Provider Manual and Medicaid Provider/Group Agreement required providers to comply with Title III of the Americans with Disabilities Act of 1990. The HSAG reviewer tested ABH's online provider directory and identified that the directory provided for searching as to whether a practice is "handicap accessible," but it did not allow searches based on the accessibility subcategories, such as restroom, exam room, or exam table handicap accessibility. ABH provided a provider directory screenshot that emphasized the lack of accessibility subcategories by evidencing that "handicap accessible" was the only accommodation listed in provider directory. ABH's Data Long Form Roster was not considered as evidence during the review because it was blank. ABH did not demonstrate that it analyzed the provider network's capability to provide services to members with physical or mental disabilities during the review period. During the interview, ABH staff members stated that the MCE collects special needs accommodations information during provider enrollment and every three years during recredentialing.		
Required Actions: The MCE must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.		
Basic Rule		
13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports/analyses • Exceptions approved by the State • HSAG will also use the results of the Access Standards: Time/Distance Checklist	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. PIHP a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population). 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2	• HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist **Evidence as Submitted by the MCE:** • S5R13 – 0220 ABH 2024 SA2 • S5R13 – 220 ABH 2024 SA2_Maps • S5R13 - 328 ABH 2024 Q4_Resubmit_2 • S5R13 - ABHLA_348_Adequacy Maps_2024 Q4_Resubmit 2 (coincides with 328 report data) • S5R13 – A-LA 6400.41 Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan • There were no formal exceptions submitted to LDH in 2024 **Additional Documentation:** • S5R13 - Submission of 220 Reports	
MCE Description of Process: ABHLA utilizes the state issued template(s) in this section to display both network adequacy and time/distance standards. These reports are submitted quarterly to LDH and monthly using the FTP Quest site.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan, and Network Adequacy Reports demonstrated ABH's commitment to meet the		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
access to care standards. ABH's Time/Distance Checklist and Member-to-Provider Ratio Checklist were used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified. Of note, ABH's staff members stated in narrative form that ABH did not request any exceptions from the State.		
Required Actions: The MCE must offer an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Refer to the Access Standards: Time/Distance Checklist and Member-to-Provider Ratio Checklist for specific areas of noncompliance.		
Timing		
14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE's operations that would affect the adequacy of capacity in services, including: i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. 42 CFR §438.207(c) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change **Evidence as Submitted by the MCE:** • S5R13– A-LA 6400.41 Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan • S5R14 – 0220 ABH 2024 SA2 • S5R14 – 220 ABH 2024 SA2_Maps • S5R14 - 328 ABH 2024 Q4_Resubmit_2 • S5R14 - ABHLA_348_Adequacy Maps_2024 Q4_Resubmit 2 (Data represented coincides with 328 report data)	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5R14 - 053 ABH 2024_RESUBMIT 1 – Complete Annual Behavioral Health Network Development Plan • There were no significant changes to the network in 2024 **Additional Documentation:** • S5R13 - Submission of 220 Reports	
MCE Description of Process: Subsections a, c, d, and e were inapplicable to ABHLA in CY2024. Per LDH reporting requirements, ABHLA submits network reporting semiannually for physical health and quarterly for behavioral health.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Exceptions Process		
15. To the extent the State permits an exception to any of the provider-specific network standards, MCO: a. *The MCO must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.* PAHP: a. *Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.*	**HSAG Required Evidence:** • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable **Evidence as Submitted by the MCE:** • S5R15 – 220 ABH 2024 SA2 • S5R15 – 220 ABH 2024 SA2_Maps • S5R15 – 328 ABH 2024 Q4_Resubmit_2 • S5R15 – ABHLA – 348 – Adequacy Maps – 2024 Q4 – Resubmit_2	☐ Met ☐ Not Met ☒ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.* 42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b) MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3	• S5R15 – 053 ABH 2024_Resubmit 1 • S5R15 – A-LA 6400.01 Assessment of Network Adequacy, Availability and Access to Care Monitoring Plan	
MCE Description of Process: ABHLA keeps LDH informed of network deficiency using the monthly Behavioral Health Network Development Plan and Annual 053 report. There have been no formal exception requests made.		
HSAG Findings: During the virtual review, ABH staff members stated that the MCE did not submit any formal exceptions to the State for consideration and approval. Therefore, HSAG has determined that this requirement is not appliable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	10	X	1	=	10
	Not Met	=	4	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	14	**Total Score**		=	10

Total Score ÷ Total Applicable	=	**71%**

Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Primary Care Physician Access		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. *MCO:* a. *PCP appointments are available as follows:* i. *non-urgent sick primary care: 72 hours* ii. *Non-urgent routine primary care: 6 weeks* *PAHP:* a. *Primary dental care: within 30 days* b. *Follow-up dental services: within 30 days after assessment* **Evidence as submitted by the MCE:** • S5AR1A- Access Standards 2024 Report	Y ☐ N ☒ NA ☐
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. *MCO:* a. *For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide*: b. *Specialist appointments: one month* c. *Non-urgent routine behavioral health care: 14 days* d. *Urgent non-emergency behavioral health care: 48 hours* e. *ASAM Level 3.3, 3.5, and 3.7: 10 business days* f. *Residential withdrawal management: 24 hours when medically necessary* g. *Psychiatric Residential Treatment Facility (PRTF): 20 calendar days* *PAHP:* a. *Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	i. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* ii. *Primary dental care: within 30 days* iii. *Follow-up dental services: within 30 days after assessment* *PIHP:* a. *Urgent non-emergency behavioral health care: 48 hours*	
	Evidence as submitted by the MCE: • S5AR2BCD- Access Standards 2024 Report • Regarding parts (e) through (g) - It is atypical for a member to call this facility to set up services for themselves. Provider must refer member to a particular level of care.	
Hospital and Emergency Services Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1	3. *MCO:* a. *Emergency care: 24 hours, 7 days/week within one hour of request* b. *Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request* c. *After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes* *PAHP:* a. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* *PIHP:* *1. Emergent care: 24 hours, 7 days/week within one hour of request* *2. Emergent, crisis or emergency services must be available at all times.* *3. Urgent care: 24 hours, 7 days/week within 48 hours of request*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • Emergency Rooms and Urgent Cares will take into account the urgency of need, and do not take appointments. Therefore these standards cannot be assessed using appointment wait time/availability.	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. *MCO:* a. *OB/GYN care for pregnant women:* i. *1st trimester: 14 days* ii. *2nd trimester: 7 days* iii. *3rd trimester: 3 days* iv. *High risk pregnancy, any trimester: 3 days* b. *Family planning appointments: 1 week*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • S5AR4A- Access Standards 2024 Report	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: None PAHP Contract: None PIHP Contract: None	5. *MCO:* *PAHP:* *PIHP:*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • NA	

Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* **Evidence as submitted by the MCE:** • S5B – 220 ABH 2024 SA2 *1. Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000 – Tab 2: Ratios / Line(s) - 16-22* *2. Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000 – Tab 2: Ratios / Line(s) 26-33*	Y ☒ N ☐ NA ☐
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: None PAHP Contract: None PIHP Contract: None	3. *Acute Inpatient Hospitals* **Evidence as submitted by the MCE:** S5B – 220 ABH 2024 SA2 (Tab 2 / Ratios) • Current LDH 0220 template does not include ratio standards on Tab 2 (Ratios) S5B – LA220 SA2 Geo Maps • Map C1 Urban / Map C2 Rual	Y ☐ N ☐ NA ☒
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	4. *Laboratory* 5. *Radiology* 6. *Pharmacy* 7. *Hemodialysis Centers*	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	**Evidence as submitted by the MCE:** • Current LDH 220 template does not include ratio standards on Tab 2 (Ratios) for the specialties within this section. GeoMaps are available. See S5B – LA220 SA2 Geo Maps 4. *Laboratory – Map D1 Urban / Map D2 Rural* 5. *Radiology - Map E1 Urban / Map E2 Rural* 6. *Pharmacy – Map F1 Urban / Map F2 Rural* 7. *Hemodialysis Centers - Map G1 Urban / Map G2 Rural*	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. *OB/GYN: 1:10,000* 9. *Allergy/Immunology: 1:100,000* 10. *Cardiology: 1:20,000* 11. *Dermatology: 1:40,000* 12. *Endocrinology and Metabolism: 1:25,000* 13. *Gastroenterology: 1:30,000* 14. *Hematology/Oncology: 1:80,000* 15. *Nephrology: 1:50,000* 16. *Neurology: 1:35,000* 17. *Ophthalmology: 1:20,000* 18. *Orthopedics: 1:15,000* 19. *Otorhinolaryngology/Otolaryngology: 1:30,000* 20. *Urology: 1:30,000*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • S5B – 0220 ABH 2024 SA2 8. *OB/GYN: 1:10,000 – Tab 2(Ratios) Lines 54-55* 9. *Allergy/Immunology: 1:100,000 – Tab 2(Ratios) Lines 38-39* 10. *Cardiology: 1:20,000– Tab 2(Ratios) Lines 40-41* 11. *Dermatology: 1:40,000– Tab 2(Ratios) Lines 42-43*	

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
	12. *Endocrinology and Metabolism: 1:25,000– Tab 2(Ratios) Lines 44-45* 13. *Gastroenterology: 1:30,000– Tab 2(Ratios) Lines 46-47* 14. *Hematology/Oncology: 1:80,000– Tab 2(Ratios) Lines 48-49* 15. *Nephrology: 1:50,000– Tab 2(Ratios) Lines 50-51* 16. *Neurology: 1:35,000– Tab 2(Ratios) Lines 52-53* 17. *Ophthalmology: 1:20,000– Tab 2(Ratios) Lines 56-57* 18. *Orthopedics: 1:15,000– Tab 2(Ratios) Lines 58-59* 19. *Otorhinolaryngology/Otolaryngology: 1:30,000– Tab 2(Ratios) Lines 60-61* 20. *Urology: 1:30,000– Tab 2(Ratios) Lines 62-63*	
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	21. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500* **Evidence as submitted by the MCE:** • S5B – 0220 ABH 2024 SA2 ○ *Tab 2(Ratios) - Lines 16-19 – LDH template ratio indicates 1:1,000 enrollees*	Y ☒ N ☐ NA ☐
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	22. *Adult Physician Extenders: 1:1,000* **Evidence as submitted by the MCE:** • S5B – 0220 ABH 2024 SA2 ○ *Tab 2(Ratios) - Lines 20-22*	Y ☒ N ☐ NA ☐
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	23. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500* **Evidence as submitted by the MCE:** • S5B – 0220 ABH 2024 SA2	Y ☒ N ☐ NA ☐

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	○ *Tab 2(Ratios) - Lines 26-30 – LDH template ratio indicates 1:1000 enrollees*	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	24. *Pediatric Physician Extenders: 1: 1,000* **Evidence as submitted by the MCE:** • S5B – 0220 ABH 2024 SA2 ○ *Tab 2(Ratios) - Lines 31-33*	Y ☒ N ☐ NA ☐

Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: 2.6.2.6.1 PIHP Contract: None	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 3. *Primary Dental Services:* *a. Rural Parishes: 30 miles one-way* *b. Urban Parishes: 10 miles*	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • S5C - 220 ABH 2024 SA2_Maps – Adult PCP: Urban: Map A1 / Rural: Map A2 – Pediatric PCP: Urban: Map B1 / Rural: Map B2 – Primary Dental Services: LDH manages the dental benefit through their vendors: DentaQuest and MCNA.	
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F	4. *Acute Inpatient Hospitals* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • S5C - 220 ABH 2024 SA2_Maps	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
PAHP Contract: None PIHP Contract: None	– Urban: Map C1 – Rural: Map C2	
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	5. *Laboratory:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 6. *Radiology:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 7. *Pharmacy:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 8. *Hemodialysis Centers:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • S5C - 220 ABH 2024 SA2_Maps – Laboratory: Urban: Map D1 / Rural: Map D2 – Radiology: Urban: Map E1 / Rural: Map E2 – Pharmacy: Urban: Map F1 / Rural: Map F2 – Hemodialysis Centers: Urban: Map G1 / Rural: Map G2	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	9. *OB/GYN:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Contract MCO Contract: Amendment F PAHP Contract: 2.6.2.6.2 PIHP Contract: None	10. *Allergy/Immunology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 11. *Cardiology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 12. *Dermatology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 13. *Endocrinology and Metabolism:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 14. *Gastroenterology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 15. *Hematology/Oncology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 16. *Nephrology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 17. *Neurology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 18. *Ophthalmology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	19. *Orthopedics:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 20. *Otorhinolaryngology/Otolaryngology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 21. *Urology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 22. *Psychiatrists:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 23. *Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 24. *Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 25. *Specialty Dental Services* a. *Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees.*	
	Evidence as submitted by the MCE: • S5C - 220 ABH 2024 SA2_Maps • OB / GYN: Urban: Map H1 / Rural: Map H2	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	• Allergy / Immunology: All Members: Map I1 • Cardiology: All Members: Map J1 • Dermatology: All Members: Map K1 • Endocrinology and Metabolism: All Members 21+: Map L1 / Pediatric: Map L2 • Gastroenterology: All Members: Map M1 • Hematology / Oncology: All Members: Map N1 • Nephrology: All Members: Map O1 • Neurology: All Members 21+: Map P1 / Pediatric Map P2 • Ophthalmology All Members: Map Q1 • Orthopedics: All Members 21+: Map R1 / Pediatric: Map R2 • Otorhinolaryngology / Otolaryngology: All Members: Map S1 • Urology: All Members: Map T1 • Psychiatrics: See ABHLA 348 Adequacy Maps_2024_Q4_Resubmit_2 – Urban: Map A1 / Rural: Map A2 • Physicians and LMHP who specialize in Pregnancy-Related and Postpartum MH Disorders: See ABHLA 348 Adequacy Maps_2024_Resubmit 2 – Urban: Map B1 / Rural: Map B2 • Physicians and LMHP who specialize in Pregnancy-Related and Postpratum SUD: See ABHLA 348 Adequacy Maps_2024_Resubmit 2 – Urban: Map B3 / Rural: Map B4 • Specialty Dental: LDH manages the dental benefit through their vendors: DentaQuest and MCNA.	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Licensed Mental Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	26. *Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • NA - per LDH guidelines, there is no Time_Distance standard for APRN / LCSW / Psychology.	Y ☐ N ☒ NA ☐
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	27. *PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization* *a. Rural and Urban Parishes: 200 miles* **Evidence as submitted by the MCE:** • S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – PRTF Access for Pediatric Members Under Age 21 ○ Map E1 ○ PRTF services in 348 align with LDH requirements	Y ☒ N ☐ NA ☐
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	28. *ASAM Level 1:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 29. *ASAM Level 2.1:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	30. *ASAM Level 2WM:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	
	Evidence as submitted by the MCE: • For all following Levels of Care, see S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – ASAM Level 1: Urban: Map F1 / Rural: F2 – ASAM Level 2.1: Urban: Map F3 / Rural: F4 – ASAM Level 2WM: Urban: Map F5 / Rural: F6	
Substance Use Residential Treatment Facilities (adult)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	31. *ASAM Levels 3.1* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 32. *ASAM Levels 3.3* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 33. *ASAM Levels 3.5* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 34. *ASAM Levels 3.2-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 35. *ASAM Level 3.7* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	36. *ASAM Level 3.7-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	
	Evidence as submitted by the MCE: • For all following Levels of Care, see S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – ASAM 3.1: Urban: Map G1 / Rural: G2 – ASAM 3.3: Urban: Map G5 / Rural: G6 – ASAM 3.5: Urban: Map G7 / Rural: G8 – ASAM 3.2 WM: Urban: Map G3 / Rural: G4 – ASAM 3.7: Urban: Map G9 / Rural: G10 – ASAM 3.7WM: Urban: Map G11 / Rural: G12	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	37. *ASAM Level 3.1* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 38. *ASAM Level 3.2 Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 39. *ASAM Level 3.5* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • For all following Levels of Care, S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – ASAM 3.1: Map G13	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	– ASAM 3.2 WM: Map G14 – ASAM 3.5: Map G15 • Services are mapped in accordance to LDH guidelines	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	40. *Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 90 miles* **Evidence as submitted by the MCE:** • For all following Levels of Care, see S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – Urban: Map I1 – Rural: Map I2	Y ☒ N ☐ NA ☐
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	41. *Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • For all following Levels of Care, see S5C - ABHLA_348_Adequacy Maps_2024_Q4_Resubmit 2 – Urban: Map H1 – Rural: Map H2	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Behavioral Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	42. *For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • Not applicable to ABHLA	Y ☐ N ☐ NA ☒
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	43. *For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** • Not applicable to ABHLA	Y ☐ N ☐ NA ☒

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		
Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).		
1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or member notice • Primary care provider (PCP) assignment algorithm • Screenshot of member identification (ID) card • Screenshot of fields designating the assigned PCP and assigned case manager • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_ICM Program Description 2024, pg. 6 • S6_AMA 7500.05 Integrated Care management corporate policy, pg. 3, 7-8 • S6_2024 Member Handbook, pg 9-11, 20 • S6R1_Screenshot of member ID card • S6R1_Screenshot of assigned PCP	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• S6R1 Member ID Card Proof Redacted • S6R1 Member ID Card Proof BH Only Redacted • S6_AMA 7000.40 Member Transition Policy Amendment, p 10 • S6R1_A-LA 4400.15 Enrollee Member Enrollment, pg 4-5 • S6_Mbr_Care Plan Letter Enhanced, entire document • S6_AssignADoc Application handbook, entire document	
MCE Description of Process: Integrated Care Management (ICM) is Aetna Medicaid Care Management's model for care management, case management, and care coordination services. The purpose of this policy is to describe Aetna Better Health's requirements and guidelines regarding the ICM model including programs for episodic care management, Children Specialties (CS), those with special healthcare needs and chronic condition management.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE coordinates the services the MCE furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid.	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Transition of care program • Workflow for coordinating with other MCOs/ PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
d. With the services the member receives from community and social support providers. MCO: a. *Coordinate care between network PCPs and specialists, including specialized behavioral health providers;* b. *Coordinate care for out-of-network services, including specialty care services;* c. *Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;* d. *Coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed.* PAHP: a. Coordination with the enrollee's MCO: i. *for oral health issues exceeding the coverage of the Contract;* ii. *for transportation to and from covered dental services; and* iii. *regarding value-added dental benefits offered by the enrollee's MCO.* PIHP: a. *Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.*	• HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6R2 _AMA 7000.43 Coordination of Member Care Corporate Policy, pg 2-6 • S6R2_AMA 7000.43 Coordination of Member Care Policy Amendment, pg 1 • S6_AMA 7500.05 Integrated Care management Corporate Policy, pg 2-3, 23-24 • S6_AMA 7500.05 Integrated Care Management Policy Amendment, pg 8 • S6_CSoC Waiver Referral Job Aid, entire document • S6_2024 ABHLA Provider Manual, pg 123-124 • S6_AMA 7000.40 Member Transition Corporate Policy, p 2, 4, 12 • S6_ICM Program Description, pg 22-24 • S6R2_Care Transitions Workflow, entire document • S6R2_Transition Between Health Plans Job aid, entire document.	

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
b. *Coordinate care for out-of-network services.* c. *Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.* d. *Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.* 42 CFR §438.208(b)(2) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7		
MCE Description of Process: Aetna Better Health provides care coordination to members from initial enrollment throughout discharge including transitions. Aetna Better Health will coordinate care between services and payer/providers. Referrals to community resources and providers for coordination with community and social services. Transitions between health plans covering both FFS and other MCO's as well as payers are also coordinated upon request. Pharmacy resource referrals are also provided as a means of coordination of care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual case management performance evaluation (CMPE) file review demonstrated overall compliance with service coordination.		
Required Actions: No action required.		
3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. MCO:	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • S6_AMA 7500.05 Integrated Care management corporate policy, pg. 23, 24 • S6 ICM Program Description, pg. 22-25	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
a. *The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.* 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8	• S6_AMA 7500.07 Health Risk Screening Process Amendment, pg 2 • S6_Transition Between Health Plans Job Aid, entire document • S6_AMA 7000.40 Member Transition Corporate Policy, entire document • S6_AMA 7500.40 Members with Special Healthcare Needs Corporate Policy, pg 7-8 • S6_screenshot of TOC data exchange, entire document • S6R3 Screenshot sharing of information, entire document • S6_CSoC Waiver Referral Job Aid, entire document	
MCE Description of Process: Aetna Better Health of Louisiana shares results of any identification and assessments of the member's needs to ensure continuity of care with other MCOs and state entities as requested. ABHLA also exchanges data through the TOC database to ensure services are not duplicated. ABHLA also exchanges member data with DCFS to ensure care coordination for members. 2.7.2.3 The Contractor shall provide HNA data to the Enrollee's assigned PCP, and to LDH *as requested.*		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information Sharing		
4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with the State	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO: a. *Upon written request* 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2	• Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description • Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs **Evidence as Submitted by the MCE:** • S6_AMA 7500.05 Integrated Care management corporate policy, pg. 23, 24 • S6 ICM Program Description, pg. 22-24 • S6_AMA 7500.07 Health Risk Screening Process Amendment, pg 2 • S6_AMA 7000.40 Member Transition Policy Amendment, pg 2, 8 • S6_AMA 7000.40 Member Transition Corporate Policy, entire document • S6_screenshot of TOC data exchange, entire document • S6_CSoC Waiver Referral Job Aid, entire document	
MCE Description of Process: Aetna Better Health of Louisiana shares results of any identification and assessments of the member's needs to ensure continuity of care with other MCOs and State entities as requested. ABHLA also exchanges data through the TOC database to ensure services are not duplicated. ABHLA also exchanges member data with DCFS to ensure care coordination for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.7 PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1 PIHP Contract: 16.15	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices **Evidence as Submitted by the MCE:** • S6_069 ABH 2024 Q2 Report • S6_ICM program description, pg. 14 • S6_2024 ABHLA Provider Manual, pgs. 41-43, 137-138 • S6R5_A-LA 8000.63 Provider Monitoring and Reporting, pgs. 3-4.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health ensures providers maintain appropriate member health records.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the MCE:** • S6_ICM Program Description, pg. 31	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12	• S6_AMA 7000.40 Member Transition Policy Amendment, p 2 • S6_2024 ABHLA Provider Manual, pg. 108.	
MCE Description of Process: In all of our programs, including care management, we consider a member's protected health information (PHI) private and confidential. Aetna Medicaid maintains policies and procedures to protect PHI against unlawful use and disclosure. Aetna Better Health protects member privacy in accordance with the required guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Initial Health Risk Screening		
7. The MCE makes a best effort to conduct an initial screening of each member's needs within MCO: a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.* PAHP: a. *The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial screening of the enrollee's needs and to offer to schedule the enrollee's initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment.*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_Health Needs Assessment_FINAL, entire document • S6_ICM Program description 2024, pg. 13-14 • S6_AMA 7500.07 Health Risk Screening Process Corporate policy, pg. 3 • S6_HRQ Outreach Process Job Aid, entire document	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.208(b)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA		
MCE Description of Process: The purpose of this policy is to describe Aetna Medicaid's requirements and guidelines regarding health risk screening processes and how these tools are used to support the identification of member needs and stratify members for care management including chronic condition management.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that ABH had policies, procedures, and mechanisms to conduct the initial health needs assessment (HNA); however, results from the virtual case management performance evaluation (CMPE) file review demonstrated noncompliance with timely completion of the initial HNA.		
Required Actions: The MCE must conduct an initial screening of each member's needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the HNA on at least three different occasions, at different times of the day, and on different days of the week. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of the initial HNA. This process must include HNA time frame monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.		
Comprehensive Assessment		
8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS • Comprehensive assessment template	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate. PAHP: a. *The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.* 42 CFR §438.208(c)(2) 42 CFR §457.1230(c) MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1	• HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_ICM Program description 2024, pg. 17-20, 22 • S6_AMA 7500.05 Integrated Care management corporate policy, pg. 10, 15 • S6_AMA 7500.07 Health Risk Screening Process Corporate policy, pg. 1 • S6_Care Management Definitions Corporate reference • S6_Comprehensive Assessment Care Plan Interview • S6_2024 Member Handbook, pg. 44.	
MCE Description of Process: Integrated Care Management (ICM) is Aetna Medicaid Care Management's model for care management, case management, and care coordination services. The purpose of this policy is to describe Aetna Better Health's requirements and guidelines regarding the ICM model including programs for episodic care management, Children's Specialty (CS), those with special healthcare needs, and chronic condition management. ABHLA does not have a contract to manage the LTSS population for Louisiana.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with the timely completion of the comprehensive assessments and reassessments.		
Required Actions: No action required.		
Treatment/Service Plan		
9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Person centered treatment plan template	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
through assessment to need a course of treatment or regular care monitoring. 42 CFR §438.208(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3	• HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_ICM Program description 2024, pg. 9 • S6_AMA 7500.05 Integrated Care Management Corporate policy, pgs. 2, 13, 16, 19 • S6_2024 ABHLA Provider Manual, pg. 119-120 • S6_Comprehensive Assessment Care Plan Interview, entire document • S6_Mbr_Care_Plan letter enhanced, entire document.	
MCE Description of Process: Integrated Care Management (ICM) is Aetna Medicaid Care Management's model for care management, case management, and care coordination services. The purpose of this policy is to describe Aetna Better Health's requirements and guidelines regarding the ICM model including programs for episodic care management, Children's Specialty (CS), those with special healthcare needs and chronic condition management. ABHLA does not have a contract to manage the LTSS population for Louisiana.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with the timely completion of a plan of care (POC).		
Required Actions: No action required.		
10. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member.	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the MCE in a timely manner, if this approval is required by the MCE. d. In accordance with any applicable State quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3	• Mechanisms to actively involve the member and the member's formal and informal supports in the development of the treatment plan • Mechanisms to actively involve the member's PCP (and any other providers involved in the member's care) in the development of the treatment plan • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_ICM Program description 2024, pg. 4-5, 9,23-25 • S6_AMA 7500.05 Integrated Care Management Corporate policy, pg. 3-5, 15, 19-24 • S6R10_A-LA 3000.25 Contractually Required Staffing and Job Descriptions, pg 13, 15-16 • S6 Comprehensive Assessment Care Plan Interview, entire document • S6_Mbr_Care_Plan letter enhanced, entire document.	
MCE Description of Process: Integrated Care Management (ICM) is Aetna Medicaid Care Management's model for care management, case management, and care coordination services. The purpose of this policy is to describe Aetna Better Health's requirements and guidelines regarding the ICM model including programs for episodic care management, Children's Specialty (CS), those with special healthcare needs and chronic condition management. ABHLA does not have a contract to manage the LTSS population for Louisiana.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance in the development of POCs that are person-centered and include goals, risks, behavioral health, and supports.		
Required Actions: No action required.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3). 42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Care plan and service plan review and revision tracking mechanism • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6R10b – ICM Program description 2024, pg. 28, 32-35 • S6_AMA 7500.05 Integrated Care Management Corporate policy, pg.15-16, 20-23 • S6_Care Plan Development Job Aid, entire document.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Integrated Care Management (ICM) is Aetna Medicaid Care Management's model for care management, case management, and care coordination services. The purpose of this policy is to describe Aetna Better Health's requirements and guidelines regarding the ICM model including programs for episodic care management, Children's Specialty (CS), those with special healthcare needs and chronic condition management.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with conducting timely POC updates.		
Required Actions: No action required.		
Direct Access to Specialists		
12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism	**HSAG Required Evidence:** • Policies and procedures • Care management program description	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1	• Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the MCE:** • S6 7500.40 Members with Special Healthcare Needs Policy, p 1, 7 • S6_2024 ABHLA Provider Manual, pgs. 119-120 • S6_2024 Member Handbook, pgs. 23, 59-60, 67-68 • S6_ICM Program description 2024, pgs. 25,32-35	☐ NA
MCE Description of Process: The purpose of this policy is to outline a process for the identification, assessment, case management, and coordination of care for members with Special Health Care Needs (SHCN) to support their access to and receipt of appropriate health care by encouraging access to specialists, ancillary providers, and community resources.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VI—Coordination and Continuity of Care							
Total	Met	=	11	X	1	=	11
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	12	**Total Score**		=	11

Total Score ÷ Total Applicable	=	**92%**

Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The MCE: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d) MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3 PAHP Contract: 2.4.1.4 PIHP Contract: 4.1.2; 4.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and benefits grid • Utilization Management (UM) program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • S7_Prior Authorization Policy, pg 1-2 • S7_Prior Authorization Amendment pg 2 • S7_ UM Criteria_Aetna Medicaid Louisiana, pg 2-3 • S7_Member Handbook, pg16 • S7_2024 ABHLA UM Program Description, pg 5	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan will ensure that services are sufficient in an amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • S7 Prior Authorization Policy, pg 1 • S7 UM Criteria_Aetna Medicaid Louisiana, pg 2-3 • S7_2024 ABHLA UM Program Description, pg17	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Utilization management decision-making is based solely on appropriateness of care and service, the existence of coverage and the eligible member's individual needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that: MCO, PAHP, and PIHP: a. The services furnished can reasonably achieve their purpose. MCO and PIHP: a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects	**HSAG Required Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • S7_Prior Authorization Policy pg 1 • S7_Prior Authorization Amendment pg 2-3	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
the member's ongoing need for such services and supports. b. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10	• S7_UM Criteria_Aetna Medicaid Louisiana, pg 2-3 • S7_2024 Member Handbook pg 52, 60, 69 • S7_2024 ABHLA Provider Manual, pg 46	
MCE Description of Process: The health plan may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization management (with the exception of Early and Periodic Screening, Diagnosis and Treatment [EPSDT services]), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE specifies what constitutes "medically necessary services" in a manner that: a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses the extent to which the MCE is responsible for covering services that address:	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S7_Prior Authorization Amendment pg 3 & 9	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5) MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11	• S7_i024 Member Handbook pg 20, 43 • S7_2024 Provider Manual, pg 91	
MCE Description of Process: The health plan adopts evidence-based clinical practice guidelines from nationally recognized sources. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care and reduce unnecessary variations in care. The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Authorization of Services		
5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing utilization management • Delegated written contract (for entities responsible for delegated UM functions)	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the MCE:** • S7_Prior Authorization Amendment pg. 8 • S7_UM Criteria_Aetna Medicaid Louisiana, pgs. 2-3 • S7R5_2024 ABHLA UM Program Evaluation, pg. 21 • S7R5_List of Delegated UMs, entire document • S7_2024 ABHLA UM Program Description, pg16 • S7R5_eviCore National Radiology Management Services Agreement Executed 01012014, entire document • S7R5_Delegation Oversight Policy 8000.60, pg 10-11	
MCE Description of Process: The Utilization Management department has written policies and procedures that demonstrate commitment and adherence to federal, state, and regulatory requirements. The requesting practitioner or provider is responsible for complying with the health plan's authorization requirements, policies, and request procedures to facilitate reimbursement of claims.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	• Results of inter-rater reliability (IRR) activities **Evidence as Submitted by the MCE:** • S7R6_AMA 7000.30 Approving and Applying Medical Necessity Criteria, pg 2 • S7_UM Criteria Aetna Medicaid Louisiana, pg 4 • S7_2024 ABHLA IRR Analysis, entire document • S7R6 7000.10 Inter-rater Reliability Policy (whole Policy) • S7_2024 ABHLA UM Program Description, pg29 **Additional Documentation:** • S7R5_eviCore National Radiology Management Services Agreement Executed 01012014 • S7R6_Evicore Interrater Reliability Assessment, entire document • S7R6 - Compliance Training alert Past Due example_Redacted	
MCE Description of Process: The health plan monitors inter-rater reliability (IRR) to evaluate the objectivity and consistency with which staff members and external reviewers apply medical review criteria.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. The MCE consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the MCE:** • S7_Prior Authorization Policy pg. 3 • S7_UM Timeliness Standards and Decision Notification pg. 5 • S7R7 P2P Case 1-240917019067 • S7R7 P2P Case 2- 240520073185 • S7R7 P2P Case 3- 240528003119 • S7_ABHLA Provider Manual, pg. 126 • S7_2024 ABHLA UM Program Description, pgs. 17, 23-24. **Additional Documentation:** • S7R7_Informal Reconsideration Desktop Process_Redacted, entire document • S7R7_Informal Reconsideration Contract language, entire document	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Consultation with the treating physician and/or other reliable sources (e.g., facility utilization review nurse/discharge planner) is part of the coverage determination process when necessary.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has scored this element as not applicable since State requirements differ from federal requirements. In the virtual review, ABH staff members described that when a prior authorization request is denied by a reviewer (such as medical director), the provider is issued an adverse benefit determination (ABD) notice via fax and letter which informs the provider of the right to request a peer-to-peer (within a specified time frame). An ABD notice is also sent to the member at this point in time (prior to the peer-to-peer). If requested, a peer-to-peer consultation is scheduled, and if the denial decision is overturned, that is noted in the member record and the service is approved. At this point, all the notifications are regenerated indicating approval. ABH's documentation and its description of this process during the virtual review indicated that it has an informal reconsideration process as per its contract with LDH. However, CMS has articulated that MCEs' practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member an ABD notice is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS' definition of an appeal. HSAG has communicated this information to LDH.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
8. The MCE authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans **Evidence as Submitted by the MCE:** • N/A: ABHLA is not currently contracted to manage this population	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A ABHLA is not currently contracted to manage this population		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract. Therefore, this requirement will be scored as not applicable.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health. MCO: a. *The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.* PAHP: a. *Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition.* 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_2024 ABHLA UM Program Description, pg 11, 12, & 18 • S7_Prior Authorization policy, pg. 1 • S7_Provider Manual pg 122 • S7_UM Nurse consultant job description • S7R7 UM Medical Director Job Description • S7R9-A-LA 3000.25 Contractually Required Staffing and Job Descriptions, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABHLA Medical Directors have a current, unencumbered license through the Louisiana state board of medical examiners. All adverse medical necessity decisions are reviewed and determined by a medical director.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Notice of Adverse Benefit Determination		
10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. MCO: a. *The MCO shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.* PIHP: a. *The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The PIHP shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.* 42 CFR §438.210(c) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM Timeliness Standards and Decision Notification Policy pg 4 • S7_UM Timeliness Standards and Decision Notification-Louisiana Amendment pg 5 • S7_2024 ABHLA UM Program Description, pg 6 & 24 • S7_MCD_LA02 -LA Medicaid IP Denial Full • S7_MCD_LA02 IP Partial Denial • S7_MCD_LA03 LA Medicaid OP Denial Full • S7_MCD_LA03 -LA OP Medicaid Partial • S7_MCD_LA05 - LA Medicaid Extension - NonChisolm	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health provides written notice to providers of any adverse benefit determination as it relates to amount, duration, or scope.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
11. The MCE defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. 42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S7R11 A-LA 3100.90 Enrollee Grievance Policy, pg 1-2 • S7_UM Timeliness Standards and Decision Notification Policy pg 4 • S7_LA 3100.70 Member Appeals Policy • S7_2024 Member Handbook, pg 72 • S7_2024 ABHLA Provider Manual, pg 122, 143, 168-170 • S7R11 f*	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2) MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1		
MCE Description of Process: Aetna Better Health of Louisiana provides written notice to providers and members of any adverse benefit determination as it relates to amount, duration, or scope. *Louisiana Medicaid does not have a sole MCE in any region within the state.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: a. The ABD the MCE has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the MCE's ABD, including information on exhausting the MCE's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c).	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM Timeliness Standards and Decision Notification Policy, pg 5 • S7_2024 ABHLA UM Program Description, pg 6, 24-26 • S7_2024 Provider Manual, pg 131-132 • S7_2024 Member Handbook pg 75 • S7_MCD_LA02 -LA Medicaid IP Denial Full • S7_MCD_LA02 IP Partial Denial	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. g. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2	• S7_MCD_LA03 LA Medicaid OP Denial Full • S7_MCD_LA03 -LA OP Medicaid Partial • S7_MCD_LA05 - LA Medicaid Extension – NonChisolm **Additional Documentation:** • S7RS7_LDH Letter Companion Guide, pgs. 12-13 • S7_Denial Letter_1_240123006579_grade level • S7_Denial Letter_2_241119046511_grade level • S7_Denial letter_3_ 240207009723 grade level • S7_Denial letter_4_ 240306072366 grade level • S7_Denial letter_5_ 240313041417 grade level • S7_Denial letter_6_240920036376 grade level • S7_Denial letter_7_ 241105059292 grade level • S7_Denial letter_8_ 240816043709 grade level • S7_Denial letter_9_ 1160572609501 grade level • S7_Denial letter_10_ 1194138447122 grade level • S7_Denial letter_OS1_240927090656 grade level • S7_Denial letter_OS2_240125004842 grade level	

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health of LA provides written notice to providers of any adverse benefit determination as it relates to amount, duration, or scope. The adverse benefit determination template shall include but is not limited to information related to the member's right to an appeal, translator services, attorney rights, and copied documentation as it pertains to the determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements. For part (g) of this element, during the virtual review, ABH staff members described its process for testing the reading grade level of member letters and that, for the purposes of submission, the grade-level test may have been completed on the entire letter instead of the applicable portions. Upon resubmission, HSAG determined compliance was met. **Recommendations:** HSAG recommends that the MCE ensure member notifications meet state-required reading levels and that the MCE's documentation of reading levels for case files is accurately demonstrated. The MCE should add functionality to the system that houses and tracks prior authorization requests and resolutions so users may document that ABD notices include all requirements and indicate that the reading grade level has been verified.		
Required Actions: No action required.		
Timeframe for Decisions		
13. For standard authorization decisions, the MCE provides notice as expeditiously as the member's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM Timeliness Standards and Decision Notification Policy pg 1,2	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_UM Timeliness Standards and Decision Notification-Louisiana Amendment pg 3 • S7_ UM Task Timeliness and Aging Report • S7_ MedCompass UM Turnaround Time Management Report • S7_ MedCompass timeliness report • S7_188PH ABH 2024 Q3,entire document • S7_188BH ABH 2024 Q3,entire document • S7_2024 ABHLA UM Program Description, pg. 24.	
MCE Description of Process: ABHLA adheres to consistent standards for timeliness of coverage decisions and notification of these utilization management decisions so as not to adversely impact the health of members. These time frames and notification standards are in compliance with applicable federal regulatory, state, and accreditation requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8	**Evidence as Submitted by the MCE:** • S7_UM timeliness Standards and Decision Notification Policy pg 2 • S7_188PH ABH 2024 Q3, entire document • S7_188BH ABH 2024 Q3, entire document • S7_ UM Task Timeliness and Aging Report • S7_6edCompass UM Turnaround Time Management Report • S7_MedCompass timeliness report • S7_2024 ABHLA UM Program Description, pg 24	
MCE Description of Process: ABHLA makes coverage decisions and notifies providers and members in a timely manner. In the event an urgent/expedited authorization is requested, determinations and notices are made no later than 72hrs after the receipt to ensure the best interest of the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if: a. The member, or the provider, requests the extension; or b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • Three case examples of authorizations with an extension, including the date of receipt of the authorization request and date of the decision to extend the time frame	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9	• HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM Timeliness Standards and Decision Notification Policy pg 3 • S7_2024 Provider Manual, pg 169 • S7_ UM Task Timeliness and Aging Report • S7 MedCompass UM Turnaround Time Management Report • S7_ MedCompass timeliness report • S7_2024 ABHLA UM Program Description, pg 24 • S7R15_Extension Example 240813009546 • S7R15_Extension Example 240814051354 • S7R15_Extension Example 240827021564 • S7_Prior Authorization Amendment, pg 4 • S7_UM Timeliness Standards and Decision Notification_Louisiana Amendment_3.7.2024, pg 3	
MCE Description of Process: Please note the extension examples are Chisholm class members which have a specific process to follow for timeframes. This process is cited in the Prior Authorization Amendment policy pg 4. Aetna Better Health of Louisiana allows extensions up to 14 calendar days as long as the extension meets the required conditions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM timeliness Standards and Decision Notification Policy pg 3 • S7_2024 Provider Manual, pg 169 • S7_188PH ABH 2024 Q3, entire document • S7_188BH ABH 2024 Q3, entire document • S7_UM Task Timeliness and Aging Report • S7_MedCompass UM Turnaround Time Management Report • S7_MedCompass timeliness report • S7_Extension Example 240813009546 • S7_Extension Example 240814051354 • S7_Extension Example 240827021564 • S7_Prior Authorization Amendment, pg 4	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Please note the extension examples are Chisholm class members which have a specific process to follow for timeframes. This process is cited in the Prior Authorization Amendment policy pg. 4.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A) MCO Contract: None PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • UM program description • Three examples of notice **Evidence as Submitted by the MCE:** • S7R17_Magellan Pharmacy MCO agreement, pg 86-90 • S7_2024 ABHLA UM Program Description, pg 30 • S7R17_Pharmacy PA Denial Letter 1.2024 • S7R17_Pharmacy PA Denial Letter 2.2024 • S7R17_Pharmacy PA Denial Letter 3.2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Prior authorization determinations are delegated to Magellan Outpatient Pharmacy reviews. In virtual review, staff described that pharmacy prior authorizations are received by the MCE (routed as described for previous elements) and routed to the pharmacy team for authorization. The same monitoring and tracking systems apply to pharmacy PAs and tracking is included in all reporting and dashboards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Three case examples of advance notices, including the ABD notice and the effective date of decision • HSAG will also use the data from the universe file • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the MCE:** • S7_Prior Authorization Policy pg 6 • S7_2024 ABHLA UM Program Description pg 22 • S7_2024 ABHLA Provider Manual, pg 130 • S7R18_SIU Referral for Member Fraud Desktop, pg 1 • S7_UM timeliness Standards and Decision Notification Policy pg 4 • S7_AMA 7100.50 Louisiana Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services Policy, pg 8-9	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_Assertive Community Treatment (ACT) Services denial notice, entire document	
MCE Description of Process: ABHLA provides written notice to providers of any adverse benefit determination as it relates to amount, duration, or scope. The adverse benefit determination template shall include but is not limited to information related to the member's right to an appeal, translator services, attorney rights, and copied documentation as it pertains to the determination. ABD notice is faxed/ mailed as expeditiously as possible from date of receipt of request per contract timeframes for Termination, suspension, or reduction of previously authorized services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. The MCE may send a notice not later than the date of action if: a. The MCE has factual information confirming the death of a member; b. The MCE receives a clear written statement signed by a member that: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address;	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element (one example must apply to a deceased member, one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3	**Evidence as Submitted by the MCE:** • S7 Prior Authorization Policy pg 6 • S7_2024 ABHLA UM Program Description pg 22 • S7_2024 ABHLA Provider Manual, pg 130 • S7_SIU Referral for Member Fraud Desktop, pg 1 • S7 MCE Member Fraud Referral Template • S7R19 A-LA 4500.86 Member Disenrollment - Disruptive Member Transfer • S7_LA 3100.70 Member Appeals Policy, pg 9-10 • S7_AMA 7100.50 Louisiana Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services Policy, pg 8-9 • S7_Assertive Community Treatment (ACT) Services denial notice, entire document	
MCE Description of Process: The letters teamwork is triggered by actions from UM clinical and non-clinical tasks added to MedCompass. In virtual review, staff described that some of these scenarios are included in the discrepancy report (described in enrollment discussion). In addition, if a medical director determines that member no longer meets criteria, a notification is generated, including a transitionary period if warranted.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No required action.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
20. The MCE may shorten the period of advance notice to five days before the date of action if: a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 p.4 • S7_SIU Referral for Member Fraud Desktop, pg 1 • S7 MCE Member Fraud Referral Template • S7_LA 3100.70 Member Appeals Policy, pg 9-10	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABHLA will report to LDH when the Contractor received information about changes in an Enrollee's circumstance that may affect the Enrollee's eligibility including changes in the Enrollee's residence and death of an Enrollee. This is demonstrated in S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 p.4. The UM letters team does not generate letters in cases of potential fraud. When fraud is suspected, UM staff will report the issue to the Aetna Special Investigations Unit using the internal health care fraud form. ABHLA uses the MCE Member Fraud Referral Template to refer potential Enrollee fraud, waste, or abuse to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • Three case examples of the denial of payment on a claim, including date of the denial and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • N/A	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan mails the letter of adverse benefit determination notice at any point a clinical or administrative denial is issued by the medical director.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_UM Timeliness Standards and Decision Notification Policy, pg 2 • S7R12 188PH Expired Auths • S7R12 188BH Expired Auths • S7_MedCompass UM Task Timeliness and Aging Report, entire document • S7_MedCompass UM Turnaround Time Management Report, entire document • S7_MCD_LA02 -LA Medicaid IP Denial Full	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_MCD_LA02 IP Partial Denial • S7_MCD_LA03 LA Medicaid OP Denial Full • S7_MCD_LA03 -LA OP Medicaid Partial • S7_MCD_LA05 - LA Medicaid Extension – NonChisolm • S7_UM timeliness Standards and Decision Notification Policy pg 2	
MCE Description of Process: Process for review is within 2 business days, 2 calendar days, or 14 calendar days. Authorizations are denied per Medical Director review for no clinicals received within allotted contractual timeframes. The health plan adopted an exception to the standard and issues an administrative approval for untimely determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Compensation for Utilization Management Activities		
23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the MCE:** • S7_2024 ABHLA UM Program Description pg. 16 • S7R23 Prior Authorization Affirmative Statement Certificate 1	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7R23 Prior Authorization Affirmative Statement Certificate 2 • S7R23 Prior Authorization Affirmative Statement Certificate 3 • S7R23_Affirmation Statement Incentives Training	
MCE Description of Process: Use of standardized criteria such as MCG ensures consistent application of criteria to all requests. Staff attest each year. The health plan does not provide financial incentives for utilization management decision-makers to encourage decisions that result in underutilization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VII—Coverage and Authorization of Services							
Total	Met	=	21	X	1	=	21
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	21	**Total Score**		=	21

Total Score ÷ Total Applicable	=	**100%**

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. MCO: For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff. 42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S8R01-QM 51-Policy 2024-09-26_Assessment of Organizational Providers – entire policy – with Local Amendment A-LA 51 • S8R01-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – entire policy – with Local Amendment A-LA 53 • S8R01-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – entire policy – with Local Amendment A-LA 54 **Additional Documentation:** • S8 R1 Provider Engagement Feedback_Louisiana • S8 R1 A- LA 6200.15 Provider Experience Functions and Responsibilities • S8R1 - Q4 Fall-2024-provider newsletter • S8R1 - Q2 2024 EB+MM Provider Newsletter • S8R1 - Q324SA072 LA-Summer-2024-provider-NL-v3 • S8R1 - Q1 ABH LA Winter 2024 provider NL	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health follows all required policies and procedures in credentialing and recredentialing. The policies and procedures outline the credentialing and recredentialing of providers within the scope of Accreditation, CMS and State guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types: a. Acute; b. Primary; c. Mental health; d. Substance use disorders. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S8R02-QM 51-Policy 2024-09-26_Assessment of Organizational Providers – entire policy - with Local Amendment A-LA 51 • S8R02-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – entire policy– with Local Amendment A-LA 53 • S8R02-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – entire policy – with Local Amendment A-LA 54	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health follows all required policies and procedures in credentialing and recredentialing. The policies and procedures outline the credentialing and recredentialing of providers within the scope of Accreditation, CMS and State guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Nondiscrimination		
3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices **Evidence as Submitted by the MCE:** • S8R03-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 3, 37-38 • S8R03-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 3, 32-33 • S8R03-QM 04 Policy 2024-06-27_Confidentiality and Disclosure of Recred Recred – pages 2, 7-8 • S8R03-2024 Nondiscriminatory QM Review example – Louisiana practitioner highlighted on page 2 • S8R03-Signed CPC Member Confidentiality Statement – entire document **Additional Documentation:** • S8R03-QM 53-Policy 2025-03_27_Credentialing Allied Health Practitioners_Sate Filing	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• S8R03-QM 04-Policy 2025-02-27_Confidentiality and Disclosure of Cred Recred PR_State Filing • S8R03-QM 54-Policy 2025-05-22_pract_cred_recred_State Filing	
MCE Description of Process: The credentialing process used by Aetna, or its delegates, will be conducted in a non-discriminatory manner in accordance with the attached policies. Aetna does not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional who is acting withing the scope of his or her license or certification under state law, solely on basis of the license or certification.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's policy and procedures did not include language stating ABH does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.		
Required Actions: The MCE must update the network provider selection policies and procedures to include language that states ABH does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12.		
4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a) MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17	• HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R04-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 3, 37-38 • S8R04-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 3, 32-33 • S8R04-QM 04 Policy 2024-06-27_Confidentiality and Disclosure of Recred Recred – pages 2, 7-8 • S8R04-2024 Nondiscriminatory QM Review example – Louisiana practitioner highlighted on page 2 • S8R04-Signed CPC Member Confidentiality Statement – entire document • S8R04- Harris – CPC Termination Letter – entire document • S8R04 – ABH LA Provider-Group Contract – entire document • S8R04 – ABH LA Facility Contract – entire document **Additional Documentation:** • S08R04-CPC TERM LETTER TEMPLATE	

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: In selecting practitioners, Aetna does not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Excluded Providers		
5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3 MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3	**HSAG Required Evidence:** • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R5-Desktop for Exclusion Checks v19FEB2024	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• S8R5 – DEL_FCT_CRED001 (Delegated Function Template) - entire document • S8R05-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 17-20, 23 • S8R05-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – page 20 • S8R05-QM 62-Policy 2024-07-25_Practitioner and Peer Review –page 2 • S8R05-OIG Exclusions Individuals – entire document • S8R05-OIG Exclusions Non-Individuals • S8R05-OPM Exclusions Individuals – entire document • S8R05-OPM Exclusions Non-Individuals – entire document • S8R5 - LA Sanction Data From Oct - Dec 2024	
MCE Description of Process: A practitioner may not participate in the network if listed on the Office of Inspector General (OIG) sanctions list or the Government-wide List of Parties Excluded from Federal Procurement and Non-procurement Programs or the CMS Preclusion lists. Aetna completes monthly screenings of employees; Aetna does complete monthly screenings of providers. The first tab of S8R5 - LA Sanction Data From Oct - Dec 2024 includes the state data file data for this period, the second tab shows the net new matches after comparing the data from the first tab to our QNXT databases for the state of Louisiana.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
State Requirements		
6. The MCE complies with any additional requirements established by the State. MCO: a. *The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or that it has verified and confirmed that the provider is enrolled with the State.* b. *The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.* c. *The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even*	**HSAG Required Evidence:** • Policies and procedures • Three consecutive months of attestations submitted to LDH • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R6 - 0148 ABH 08 2024 • S8R6 – 0148 ABH 09 2024 • S8R6 -- 0148 ABH 10 2024 • S8R6 - CCIG-0006 Exclusion Screening Policy 2024 External Version • S8R6 – A-LA 3000.24 Exclusion Screening Program Policy AMENDMENT – pgs. 4-5 • S8R6 - A-LA 3000.42 Excluded Individuals • S8R6 - Desktop for Exclusion Checks v19FEB2024	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).] PIHP: a. *An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.* b. *The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.* 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4		
MCE Description of Process: A-LA 3000.42 was retired in favor of Corporate Policy 3000.24, which ABHLA adopted as an Amendment (S8R6 - A-LA 3000.24 Exclusion Screening Program Policy AMENDMENT – pgs. 4-5). ABHLA performs monthly exclusion checks against contractually-required databases, and reports any identified exclusions to LDH. Additionally, a monthly report (0148) is provided to LDH, whereby the Compliance Officer attests to the proper exclusion checks having been run and reconciled with plan providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Verification of Credentials		
7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision. a. *The MCE verifies the license directly from the state licensing or certification agency (or its website).* 42 CFR §438.214(e) MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R07-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 5, 21 • S8R07-QM 53-Policy 2025-03-27_Credentialing Allied Health Practitioners – pages 5-6, 21 • S8R07-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 5, 16 • S8R07-QM 54-Policy 2025-05-22_Practitioner Credentialing Recredentialing – pages 5, 16 • S8R7 - Staff Online License Verification (BH) **Additional Documentation:** • S8R07-QM 53-Policy 2025-03_27_Credentialing Allied Health Practitioners_Sate Filing	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna uses primary sources to verify that the practitioner has a current and valid license to practice in all states where the practitioner provides care to member and the verification is completed within 180 days of the credentialing decision. The 2025 versions of both policies have the licensure more clearly addressed on page 5.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with primary source verification requirements, specifically related to verification time frames and required documentation elements.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Required Actions: For credentialing and recredentialing, the MCE must complete primary source verification that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision. Additionally, the MCE must verify the license directly from the state licensing or certification agency (or its website).		
Practitioner Verification of Credentials		
8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision. a. *This requirement does not apply to practitioners who are not qualified to write prescriptions.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R08-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 6, 21 • S8R08-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 6, 16-17	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna must verify DEA certification is current and within 180 days of the Credentialing Committee decision date for each state where the practitioner provides care to members.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with primary source verification documentation requirements.		
Required Actions: For credentialing and recredentialing, the MCE must complete primary source verification that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision. Of note, this requirement does not apply to practitioners who are not qualified to write prescriptions.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision: a. *Board certification;* b. *Residency; or* c. *Graduation from medical or professional school.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R09-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 5-6, 24-25 • S8R09 - QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 5, 20-24	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna verifies the highest level of three levels of education and training prior to the credentialing decision: board certification, residency or graduation from medical or professional school		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with primary source verification documentation requirements.		
Required Actions: For credentialing, the MCE must complete primary source verification for the highest of the following three levels of education and training obtained by a practitioner as appropriate prior to the credentialing decision: a. Board certification; b. Residency; or c. Graduation from medical or professional school.		
10. For credentialing and recredentialing, the MCE verifies the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision. a. *Verification of board certification does not apply to nurse practitioners (NPS) or other health care professionals unless the MCO communicates board certification to members.*	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:**	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	• S8R10-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 5-6, 24 • S8R10-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 5, 20-21	
MCE Description of Process: If a practitioner claims to be board certified, Aetna must verify current board certification by an Aetna recognized board and document the expiration date of the board certification within the practitioner's credentialing file within 180 calendar days of the credentialing decision date.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with primary source verification requirements, specifically related to verification time frames and required documentation elements.		
Required Actions: For credentialing and recredentialing, the MCE must verify the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision. Of note, verification of board certification does not apply to nurse practitioners (NPs) or other healthcare professionals unless the MCO communicates board certification to members.		
11. For credentialing, the MCE verifies the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision. a. *If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.* b. *If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file.* c. *If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.* 42 CFR §438.214(e)	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R11-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – pages 6, 22 • S8R11-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – pages 6, 18	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6		
MCE Description of Process: Aetna will verify 5-year work history or curriculum vitae within 180 days of the credentialing decision date, including verification of any employment gaps of six months or greater.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's policy and procedure did not include language stating if a gap in employment exceeds six months, the MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file.		
Required Actions: For credentialing, the MCE must verify the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision. Additionally, the following must be noted: a. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date. b. If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file. c. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.		
12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R12-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – page 23 • S8R12-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – page 19	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna reviews history of any disciplinary or adverse action(s) related to practitioner professional liability claims history that resulted in settlement or judgments paid by or on behalf of the practitioner.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with primary source verification requirements, specifically related to verification time frames and required documentation elements.		
Required Actions: For credentialing and recredentialing, the MCE must verify a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]) that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.		
Practitioner Sanction Information		
13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. a. *The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R13-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – page 27 • S8R13-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – page 26 **Additional Documentation:** • S8R13 - LA sanction follow up item - Interstate alert • ABH manages a sanction dashboard tracker accessible to each state. Every state can view its providers in their state report, which includes a column showing the Sanction State. This feature provides visibility into all states that have the provider listed on their sanction list. Additionally, this information is available in	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	QNXT on the provider record, where alerts are displayed on the memos/alerts tab, accompanied by a description line that specifies the type of sanction.	
MCE Description of Process: Aetna verifies State sanctions, restrictions on licensure and limitation on scope of practice at initial credentialing and recredentialing.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's policy and procedure did not include language stating ABH verifies State sanctions, restrictions on licensure, and limitations on scope of practice in all states where a practitioner provides and/or provided care to members within the most recent five-year period available.		
Required Actions: For credentialing and recredentialing, the MCE must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, the MCE must verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.		
14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R14-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – page 23 • S8R14-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – page 19	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna verifies Medicare and Medicaid sanctions at initial credentialing and recredentialing.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's policy and procedure did not include language stating ABH verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision.		
Required Actions: For credentialing and recredentialing, the MCE must verify the Medicare and Medicaid sanctions within 180 days of the credentialing decision.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Credentialing Application/Attestation		
15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include: a. *Reasons for inability to perform the essential functions of the position;* b. *Lack of present illegal drug use;* c. *History of loss of license and felony convictions;* d. *History of loss or limitation of privileges or disciplinary actions;* e. *Current malpractice insurance coverage; and* f. *Current and signed attestation confirming the correctness and completeness of the application.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R15-QM 56-Policy 2024-02-22_Practitioner Application – page 2	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna ensures practitioner applications and attestations include confidential questions as required by accrediting and state regulatory bodies.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documents submitted for the file review did not verify compliance with current malpractice insurance coverage.		
Required Actions: For credentialing and recredentialing, the MCE must ensure that the application and attestation include current malpractice insurance coverage.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Monitoring		
16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by: a. *Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);* b. *Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and* c. *Implementing appropriate interventions when it identifies instances of poor quality.* 2 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • Provider complaints tracking reports • Provider adverse events tracking reports • Credentialing committee meeting minutes • Two examples of interventions taken based on poor quality of care **Evidence as Submitted by the MCE:** • S8R16-QM 63-Policy 2024-07-25_Review of Potential Quality of Care, pages 3-4, 6, 27-30 • S8R16-PQOC Workflow • S8R16-2024 Member Grievances Report • S8R16-2024 PQOC Adverse Action Report • S8R16-CPCMinutesNA1024 – shows a PQOC case for a Louisiana practitioner presented to and approved by the CPC	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Member complaints are reviewed regularly. Any complaints that are related to quality of care are investigated in accordance with the Potential Quality of Care (PQOC) policy, which may include an off-cycle credentialing committee for review. Complaint monitoring reports are used to identify practitioner quality issues between re-credentialing cycles. PQOC track and trend reports are shared monthly with the Credentialing Team, which provides a view of all practitioners with PQOC investigations within 36 months. Semi-annual reports identify practitioners with five or more member complaints (quality of care and quality of service) within a six-month period. Practitioners meeting the threshold may require referral to Network Manager or the Medical Director if issues have not already been addressed through the Potential Quality of Care or Office Assessment Process. Office sites are made to network practitioners if a member complaint is received regarding physical accessibility, physical appearance, or adequacy of waiting room or exam room space related to the settings in which		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
member care is delivered. There was one Louisiana Medicaid practitioner with a quality of care case investigated and presented to the credentialing committee in 2024. There were no interventions required from this investigation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Organizational Verification of Credentials		
17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State of Louisiana • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R17-QM 51-Policy 2024-09-26_Assessment of Organizational Providers – pages 1-2, 13-17	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna confirms that the provider is in good standing with State and federal regulatory bodies prior to participation in the network and every three years thereafter. The organizational provider types listed in QNXT are Hospital, Skilled Nursing, Home Health, Religious Nonmedical Health Care, Christian Science, Intermediate Care, Clinic, and Specialty Facility.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the file review did not verify that ABH confirmed the provider is in good standing with State and federal regulatory bodies.		
Required Actions: For credentialing and recredentialing, the MCE must confirm that a provider is in good standing with State and federal regulatory bodies.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body. a. *If the provider is not accredited, the MCE conducts an onsite quality assessment.* i. *The MCE has a process for ensuring that the provider credentials their practitioners.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8	**HSAG Required Evidence:** • Policies and procedures • Onsite assessment review tool/template • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8R18-QM 51-Policy 2024-09-26_Assessment of Organizational Providers – pages 2-3, 25-55	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna confirms that the provider has been reviewed and approved by an accrediting body; if the provider is not accredited, and there is not a current CMS or State Survey, Aetna conducts an onsite quality assessment prior to network participation and every three years thereafter. The assessments are included in the policy.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the file review did not confirm that providers were reviewed and approved by an accrediting body or that ABH conducted an on-site quality assessment if the provider was not accredited.		
Required Actions: For credentialing and recredentialing, the MCE must confirm that a provider has been reviewed and approved by an accrediting body; if the provider is not accredited, the MCE must conduct an on-site quality assessment. Furthermore, the MCE must have a process for ensuring that the provider credentials its practitioners.		
Time Frames		
19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements. 42 CFR §438.214(e)	**HSAG Required Evidence:** • Policies and procedures • Recredentialing timeliness report during the review period	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6	• HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review	
	Evidence as Submitted by the MCE: • S8R19-QM 51-Policy 2024-09-26_Assessment of Organizational Providers – page 4 • S8R19-QM 53-Policy 2024-09-26_Credentialing Allied Health Practitioners – page 3 • S8R19-QM 54-Policy 2024-07-25_Practitioner Credentialing Recredentialing – page 3 • S8R19 - ABHLA Recredentialing Timeliness Report CY 2024	
MCE Description of Process: Aetna completes credentialing prior to network participation and every three years thereafter.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the file review did not verify compliance with mandatory recredentialing at a minimum of every 36 months in accordance with National Committee for Quality Assurance (NCQA) requirements.		
Required Actions: The MCE must ensure that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements.		

Results for Standard VIII—Provider Selection							
Total	Met	=	6	X	1	=	6
	Not Met	=	13	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	19	**Total Score**		=	6

Total Score ÷ Total Applicable	=	**32%**

Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S9R1 - Delegation Oversight Policy 8000.60 – Entire document • S9R1 - Emergent and Non-Emergent Transportation 4500.95 – Pg 19, 23 • ABH LA_Meditrans LLC_Natl Del Master Agree_Fully Executed – A. Description of Credentialing Services 1-7 (pg. 27) – B. Performance Standards 1-5 (pg. 28) • MediTrans ABH LA 4th Amedn Net Serv Agr 10012024 FE – Section 7.30 Credentialing (last 2 pages) • Desktop National Ancillary and Delegation Oversight – Entire document **Additional Documentation:** • S9 1 - Provider HealthLink _Audit Tool 03.25	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA evaluates the ability of potential delegates to perform activities proposed for delegation and monitors delegated entities to ensure that the care or service the delegate provides on behalf of Aetna Better Health align with the standards and requirements outlined in the delegation agreement, meets accreditation and regulatory standards, and that activities performed on the plan's behalf are consistent throughout the network. Aetna Better Health acknowledges its ultimate accountability for the functions performed by delegates on its behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily. *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3 PAHP Contract: 2.15.6.3; 2.15.9 PIHP Contract: 1.5.3.1	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • S9R2 – DEL_FCT_CRED001 • S9R2 – DEL_Medicaid_Prod_Adden001 • S9R2 – DEL_MSTR_Agree001 • S9R2 – Exhibit A Louisiana Medicaid Regulatory Compliance Addendum	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA's delegation contracts comply with the requirements of the CFRs. Suppliers must provide assurances that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements and that specialty BH providers are certified in accordance with LDH certification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and MCO: a. *rules, policies, procedures, manuals, the State Plan, and Waivers.* *42 CFR §438.230(c)(2)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • Delegation Oversight Policy 8000.60 • ABHLA--HFI—RCA • S9R3 – DEL_FCT_CRED001 • S9R3 – DEL_Medicaid_Prod_Adden001 • S9R3 – DEL_MSTR_Agree001 • S9R3 – Exhibit A Louisiana Medicaid Regulatory Compliance Addendum **Additional Documentation:** • S9R3-4 - Executed RCA for MediTrans, Section 2.01	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: All subcontractors are required to sign a Regulatory Compliance Addendum (RCA). It is part of the package of subcontractor materials required for LDH review. LDH will not accept a contract package without an RCA.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's executed 2024 Exhibit A Louisiana Medicaid Regulatory Compliance Addendum (2024 Regulatory Compliance Addendum [RCA]) Section 2.01 contained a		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
"Compliance with Applicable Law" provision. ABH's delegation file submissions were also evaluated by the HSAG reviewer for this requirement, which included two executed National Delegation Master Agreements, one from July 2014 and another from March 2022, and one executed Delegated Credentialing Agreement from May 2016. While ABH stated that it "will not accept a contract package without an RCA," the July 2014 and May 2016 agreements did not include RCAs. The March 2022 agreement included an RCA albeit different than the 2024 RCA. During the interview, ABH staff members stated that in October 2024, the MCE engaged in efforts to have all subcontractors and delegated entities execute the 2024 RCA. ABH provided a subsequent 2024 RCA, which was executed in October 2024, for the March 2022 agreement. The 2024 RCA did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • ABHLA--HFI—RCA • S9R4 – DEL_FCT_CRED001 • S9R4 – DEL_Medicaid_Prod_Adden001 • S9R4 – DEL_MSTR_Agree001 • S9R4 – Exhibit A Louisiana Medicaid Regulatory Compliance Addendum **Additional Documentation:** • S9R3-4 - Executed RCA for MediTrans, Sections 5.02-5.04	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. *42 CFR §438.230(c)(3)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1		
MCE Description of Process: All subcontractors are required to sign a Regulatory Compliance Addendum. It is part of the package of subcontractor materials required for LDH review. LDH will not accept a contract package without an RCA. The RCA contains the language required in the relevant CFRs.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's executed 2024 Exhibit A Louisiana Medicaid Regulatory Compliance Addendum (2024 RCA) Sections 5.02-5.04 contained "Access to Information, Records & Systems," "Record Retention Policy," and "Audit" provisions. ABH's delegation file submissions were also evaluated by the HSAG reviewer for this requirement, which included two executed National Delegation Master Agreements, one from July 2014 and another from March 2022, and one executed Delegated Credentialing Agreement from May 2016. While ABH stated that it "will not accept a contract package without an RCA" and that the RCA "contains the language required in the relevant CFRs, " the July 2014 and May 2016 agreements did not include RCAs. The March 2022 agreement included an RCA albeit different than the 2024 RCA. During the interview, ABH staff members stated that in October 2024, the MCE engaged in efforts to have all subcontractors and delegated entities execute the 2024 RCA. ABH provided a subsequent 2024 RCA for the March 2022 agreement, which was executed in October 2024. The 2024 RCA did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contract or written arrangements indicate, and the delegate agrees that: a. The State, Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		
5. The contract or written arrangement: MCO: a. *Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.* *42 CFR §438.230* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • ABHLA--HFI—RCA • S9R5 – Exhibit A Louisiana Medicaid Regulatory Compliance Addendum – Pg. 36 Section 9.1 - Governing Law • S9R5 – ABHLA Medicaid Provider Simplicity	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: All subcontractors are required to sign a Regulatory Compliance Addendum stipulating that Louisiana law prevails without regard to its conflict of laws provisions. It is part of the package of subcontractor materials required for LDH review. LDH will not accept a contract package without an RCA. The RCA contains the language required in the relevant CFRs.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ABH's executed 2024 Exhibit A Louisiana Medicaid Regulatory Compliance Addendum (2024 RCA) Section 9.1 contained a "Governing Law" provision that stated "[t]his Agreement shall be exclusively governed by, construed and enforced in accordance with Louisiana laws, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern, which complies with this requirement," which is compliant with this requirement.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
ABH's delegation file submissions were also used by the HSAG reviewer to evaluate this requirement, which included two executed National Delegation Master Agreements, one from July 2014 and another from March 2022, and one executed Delegated Credentialing Agreement from May 2016. The March 2022 agreement included an RCA albeit different than the 2024 RCA. During the interview, ABH staff members stated that in October 2024, the MCE engaged in efforts to have all subcontractors and delegated entities execute the 2024 RCA. The MCE provided a subsequent 2024 RCA for the March 2022 agreement, which was executed in October 2024, that complied with this requirement. Of note, ABH stated that it "will not accept a contract package without an RCA" and that the RCA "contains the language required in the relevant CFRs;" however, the July 2014 and May 2016 agreements did not include RCAs. Furthermore, the July 2014 and May 2016 agreements contained Governing Law provisions, Section 12.8 and 11.8, respectively, that stated "[t]his Agreement shall be governed in all respects by the laws of the State of where Delegated Entity is located." During the interview, ABH staff members stated that the MCE's July 2014 and May 2016 agreements were executed with delegated entities that were solely located in the State of Louisiana and that these delegated entities would not avail themselves of any governing law except those of the State of Louisiana. Further research found that the delegated entity contained in the May 2016 agreement was formed in the State of Georgia, not Louisiana, in 2008. Hence, the Governing Law provision would allow for this delegated entity to avail itself to the laws of the State of Georgia should a dispute arise, which is not compliant with this requirement.		
Required Actions: The MCE must ensure that all contract or written arrangements stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the subcontractor is based and Louisiana law.		
Monitoring and Auditing		
6. Monitoring subcontractor's performance shall be monitored: MCO: a. *On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.* PAHP: a. *On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.*	**HSAG Required Evidence:** • Delegation agreement/contract template • Monitoring and audit documentation • Annual formal review • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • ABHLA--HFI—RCA • S9R6 – DEL_FCT_CRED001	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.* *42 CFR §438.230* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3	• S9R6 – DEL_Medicaid_Prod_Adden001 • S9R6 – DEL_MSTR_Agree001 • S9R6 – Exhibit A Louisiana Medicaid Regulatory Compliance Addendum • S9R6 - MediTrans 2024 Audit Results - MediTrans LLC_NVDOC Summary_01062025 • S9R6 - ABHLA_MediTrans JOC Meeting Agenda_Q1 2025 • S9R6 - ABHLA_MediTrans JOC Meeting Agenda_Q4 2024 • S9R6 - MediTrans Oversight- Q4 2024 (Q3 data) Compliance Committee **Additional Documents:** • S9R6 - Completed MediTrans Aetna Credentialing Audit Tool • S9R6 - ABHLA MediTrans - National Delegation Call Center Metrics - Corrective Action Notice 09122024 • S9R6 - ABHLA MediTrans - National Delegation Financial Audit- Corrective Action Notice 04 2024	
MCE Description of Process: ABHLA reviews subcontractor compliance quarterly in its Compliance Committee and quarterly JOCs. We conduct annual audits on policies, verification D/V (file audit), ongoing monitoring, Medicaid regulations, contract requirements, and cybersecurity. Financial audits are completed quarterly. Additionally, we monitor performance measures monthly and issue corrective action plans when they drop below the expected measure for a period of two consecutive months.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1	=	3
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	3

Total Score ÷ Total Applicable	=	**50%**

Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236(b)(1) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • S10_QAPI Program Evaluation, pgs. 79-83 • S10_Provider Site Screenshot, entire document • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pg. 1 • S10_QMOC Meeting Minutes 03.20.24, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health of Louisiana adopts clinical practice guidelines that are congruent with current NCQA standards for establishing guidelines, are based on valid and reliable clinical evidence or a consensus of health care professionals, considers members' needs, and are in consultation with contracting health care professionals. The Health Plan adopts evidence-based practice guidelines that include both medical and behavioral health conditions, represent best practice based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the chief medical officer, applicable medical committees, and if necessary, external consultants.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
2. The MCE adopts practice guidelines that consider the needs of the MCE's members and: MCO: a. adopts clinical practice guidelines for at least the conditions listed below: i. *Schizophrenia;* ii. *Attention Deficit Hyperactivity Disorder (ADHD);* iii. *Autism Spectrum Disorder;* iv. *Depression;* v. *Generalized Anxiety Disorder;* vi. *Post-Traumatic Stress Disorder;* vii. *Suicidal Behavior;* viii. *Oppositional Defiant Disorder;* ix. *Bipolar Disorder; and* x. *Substance Use Disorders.* PIHP: a. develops clinical practice guidelines for: i. *ADHD* ii. *Trauma Informed Care* iii. *Depression and Conduct Disorder* 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • S10_QAPI Program Evaluation, pgs. 79-83 • S10_Provider Site Screenshot, entire document • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pgs. 1-4 • S10_QMOC Meeting Minutes 03.20.24, entire document	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health of Louisiana adopts clinical practice guidelines that are congruent with current NCQA standards for establishing guidelines, are based on valid and reliable clinical evidence or a consensus of health care professionals, considers members' needs, and are in consultation with contracting health care professionals. The Health Plan adopts evidence-based practice guidelines that include both medical and behavioral health conditions, represent best practice based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the chief medical officer, applicable medical committees, and if necessary, external consultants.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236(b)(3) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers **Evidence as Submitted by the MCE:** • S10_QAPI Program Evaluation, pgs. 79-83 • S10_Provider Site Screenshot, entire document • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pg. 1-4 • S10_QMOC Meeting Minutes 03.20.24, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Plan presents the proposed clinical practice guidelines to the QM & UM committees annually to request feedback and recommendations related to the proposed guidelines prior to approving and adopting. Proposed practice guidelines are sent to committee participants prior to the QMUM committee meeting in which the guidelines are presented. This allows the committee providers sufficient time to review the proposed guidelines and offer recommendations and feedback during the meeting. The Health Plan adopts		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
evidence-based practice guidelines that include both medical and behavioral health conditions, represent best practice based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the chief medical officer, applicable medical committees, and if necessary, external consultants.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE adopts practice guidelines that are: MCO/PAHP: a. reviewed and updated periodically as appropriate. PIHP: a. Reviewed annually and updated periodically as appropriate. b. *Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.* 42 CFR §438.236(b)(4) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract:7.4.5.4; 7.4.7.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline • MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda **Evidence as Submitted by the MCE:** • S10_2024 ABHLA UM Program Description, pg. 16 • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pg. 4 • S10_QAPI Program Evaluation, pgs. 79-83 • S10_QMOC Meeting Minutes 03.20.24, entire document • S10_Provider Site Screenshot, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health of Louisiana adopts clinical practice guidelines that are congruent with current NCQA standards for establishing guidelines, are based on valid and reliable clinical evidence or a consensus of health care professionals, considers members' needs, and are in consultation with contracting health care professionals. Each adopted guideline is reviewed against clinical evidence at least every two years or more frequently if national guidelines change within the two-year period.		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Dissemination of Guidelines		
5. The MCE disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236(c) 42 CFR §457.1233(c) MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCE:** • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pgs. 5-6 • S10_Provider Site Screenshot, entire document • S10_2024 ABHLA Provider Manual, pgs. 126 & 133 • S10_2024 Member Handbook, pgs. 18-19, 43 • S10R5 Member site screenshot, entire document • S10 QAPI Program Evaluation, pgs. 79-83 • S10_2024 ABHLA UM Program Description, pgs. 17-18	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: In alignment with the Healthy Louisiana Medicaid Contract, Aetna Better Health of Louisiana disseminates clinical practice guidelines upon adoption, revision, and request to all contracted network providers and existing members. The Plan informs		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
providers in the Provider Newsletters and on the Aetna Better Health of Louisiana website. Clinical practice guidelines are for public reference, which allows any potential member to visit and view the Aetna Better Health of Louisiana website. The Plan informs existing members through our Plan website and member handbook.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d) 42 CFR §457.1233(c) MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Coverage guidelines/criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCE:** • S10R6_7000.30 Approving and Applying Medical Necessity Criteria Policy, pg. 2 • S10_A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines Policy, pg. 3-6 • S10R6_Member educational guidance, entire document • S10R6_Member educational guidance part2, entire document • S10_QAPI Program Evaluation, pgs. 239-240	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• S10_2024 ABHLA UM Program Description, pgs. 17-18 • S10_ 2024 Member Handbook, pgs. 18-19, 43 • S10R6_7000.10 Interrater Reliability policy, entire document • S10R6_example 1 denial notice_CPST • S10R6_example 2 denial notice_DME • S10R6_example 3 denial notice_PSR	
MCE Description of Process: Aetna Better Health of Louisiana utilizes medical necessity criteria or guidelines that are evidence-based and nationally accepted. Utilization Management staff apply medical necessity criteria based on individual member needs and an assessment of specific medical services available within Aetna Better Health of Louisiana's delivery system. Annually, the Plan conducts an Inter-Rater Reliability (IRR) assessment, which is the process of monitoring and evaluating clinical reviewers' understanding of clinical review criteria and the consistency with which different reviewers apply the same criteria in making medical and behavioral healthcare utilization decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard X—Practice Guidelines							
Total	Met	=	6	X	1	=	6
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	**100%**

Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. 42 CFR §438.242(a) 42 CFR §457.1233(d) MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations **Evidence as Submitted by the MCE:** • S11R01 - ABHLA Overview of Systems • 2024 ISCAT • 2024 ISCAT Attachments • S11R01 - LA 834 disenrollment code	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• S11R03.pdf - LA Claims Submission Amendment • S11R2 - A-LA 2000.26 Claims Management Policy _ 2024 Review • S11R03 - LA Claims Adjudication policy	
MCE Description of Process: ABH maintains Information Systems to meet all of LDH Contract requirements. Aetna Systems support the current LDH requirements, and any future Information Technology (IT) architecture or program changes. Solutions will be compliant with LDH Information Technology Resource Management (ITRM) policies, standards, and guidelines. Aetna systems interface with LDH Medicaid Management Information System Medicaid Enterprise System (MES), the LDH Virtual Gateway, and other LDH IT architecture pursuant to the MCO System Companion Guide.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Basic Elements of a Health Information System		
2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State. 42 CFR §438.242(b)(2) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Encounter Lifecycle Medical • Encounter Lifecycle Subcontractor	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• AETAMA 077955 2400.05 Encounter Data Submission • AETAMA 077963 2400.15 Correction of Encounter Data in the Encounter Management System • S11R03 - LA Claims Adjudication policy • S11R03 - Claims Submission Policy • S11R02 – A-LA 2000.26 Claims Management Policy **Additional Documentation:** • AMA 2400.05 Encounter Data Submission CORPORATE USE ONLY • AMA 2400.15 Correction of Encounter Data in EMS CORPORATE USE ONLY • S11 Element 8 & 9 Aetna Encounter Lifecycle • S11 Element 8 and 9 Vendor Lifecycle • S5R6 - A-LA 2000.20 Claims Submission Amendment _ 2024 Review • S11R2 - Claims Submission Corporate Policy	
MCE Description of Process: Finalized claims (paid/denied) are extracted from the Claims processing system once per week and imported into the Encounter Management System. Encounters are validated against compliance and business specific rules. Encounters failing validation or business edits are researched, and data validated to ensure complete and accurate data is submitted to the state.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
3. The MCE ensures that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11R03.pdf - LA Claims Submission Amendment • S11R2 - A-LA 2000.26 Claims Management Policy _ 2024 Review • S11R03 - LA Claims Adjudication policy • S11R03 – 0221 ABH 2024 10 • S11R03 – 0221 ABH 2024 11 • S11R03 – 0221 ABH 2024 12	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna utilizes various approaches to verify provider information. The tools used apply rules and examine provider data to minimize errors and ensure systems comply with the standards mandated by the State and our internal compliance teams. Medicaid Provider Operations Support: Provider Data Accuracy The source system for Aetna Medicaid provider data is QNXT and the provider module in QNXT feeds provider directories, claims, PCP and member assignment, encounters and reporting. There are certain tools used to ensure record configuration is clear and accurate.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
1. RosterPro: RosterPro is used to process large data files in order to drive demographic updates in QNXT. The benefits: Data Validation: The tool provides checks and balances against the data in QNXT*, ensuring that only accurate and valid data is updated. Standard Output: RosterPro generates standard format that adhere to established standards, promoting consistency and ease of reference. 2. ProData V1 (Light): ProData serves as the primary data input tool for the single updates in QNXT. The benefits: Data Accuracy: ProData V1 built-in system logics enhance data accuracy by identifying and rectifying discrepancies before the data is loaded into QNXT.* Clean Data Load: By ensuring that only clean and accurate data is input, ProData minimizes the occurrence of errors or issues during claim processing. Efficient Workflow: The tool streamlines the data input process, allowing the team to handle data more efficiently and focus on other critical tasks. 3. ProData V2 (Bulk): ProData is able to make thousands of updates more efficiently. The benefits: Expedited Updates: ProData V2 automates large updates of provider demographic data, expediting the process and reducing manual efforts. Data Integrity: The tool includes checks and balances to keep data clean, preventing the entry of bad data. Rules Enforcement: ProData V2 applies multiple rules to mitigate bad data entry, ensuring efficiency and adherence to standards. 4. Error Logic Reports: Error Logic Reports play a vital role in identifying and resolving data errors and inconsistencies. The benefits: Data Quality Assurance: Error Logic Reports help maintain clean data by identifying and resolving issues promptly. Continuous Improvement: Rules within the reports are regularly updated to ensure efficiency and compliance with changing requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE makes all collected data available to the State and upon request to CMS. 42 CFR § 438.242(b)(4) 42 CFR §457.1233(d) MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • 2024 ISCAT • 2024 ISCAT Attachments • 2024 Life of a Claim	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health gathers information from multiple sources, stores in systems adhering industry and required standards, and collaborates closely with LDH, following data exchange protocols outlined in numerous published Technical Manuals. The State MES system aims to maintain continuity of care for Medicaid members and ensure provider network enrollment standards are met. Aetna is committed to supporting this effort by providing the necessary and requested data.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Claims Processing		
5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F) MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • 2024 ISCAT • 2024 ISCAT Attachments • S11 – IT Systems and Workflow • AMA 2000.20 - Claims Submission	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health ensures its claims processing and retrieval systems (QNXT) are able to collect data elements necessary to enable electronic claims processing and retrieve information required by LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed; b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCE:** • S11R06 – Third Party Applications • S11R06 – Medicaid Web Portal Runbook • S11R06 – Medicaid Web Portal Mobile Runbook • S11R06 - Specialty Application Programming Interfaces (APIs) Policy **Additional Documentation:** • Mobile API Runbook (3) doc – Page 4 – Carousel 1 – API to Provider Data and Member Data • Portal API Runbook doc – Page 7 Data Access – API to Provider and Member Data. • S11R6-7 - API DOC-077048 Interoperability and Patient Access Final Rule outlines the	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: None PAHP Contract: None PIHP Contract: None	implementation of a Patient Access API as specified in 42 CFR §431.60.	
MCE Description of Process: Members have access to review details about claims, authorization, interface directly with Care Managers and more through the interface provided by the Aetna Web Portal.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that ABH prioritize continued Application Programming Interface (API) development as it is essential for not only enabling valuable business functions but also meeting federal regulatory requirements.		
Required Actions: No action required.		
7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the MCO's website. 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d) MCO Contract: 2.13.2.3 PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6 PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the MCE:** • S11R06 - Specialty Application Programming Interfaces (APIs) Policy • S11R06 – Third Party Applications • S11R06 – Medicaid Web Portal Runbook • S11R06 – Medicaid Web Portal Mobile Runbook	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Mobile API Runbook (3) doc – Page 4 – Carousel 1 – API to Provider Data and Member Data • Portal API Runbook doc – Page 7 Data Access – API to Provider and Member Data. • Also included is the S11R6-7 - DRAFT for August submission ABHLA 07012025 LDH_CMS0057_MCE_Compliance_Plan_May-28-2025.IO Response (002), which demonstrates the API compliance plan for the requirements moving forward in 2027 from CMS. • S11R6-7 - API DOC-077048 Interoperability and Patient Access Final Rule outlines the implementation of a Patient Access API as specified in 42 CFR §431.60	
MCE Description of Process: ABHLA maintains publicly accessible API for Provider Directory. ABHLA Members, Providers, and the public have access to search for a participating provider network using the names, specialty, and/or location. Search can be further narrowed using one or more filters.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: No action required.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Member Encounter Data		
8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5 PIHP Contract: 15.2.2.3; 15.2.2.9	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • AETAMA 077955 2400.05 Encounter Data Submission • AETAMA 077963 2400.15 Correction of Encounter Data in the Encounter Management System • AETMA 077965 2400.20 Processing of Encounter Response File Information • Encounter Lifecycle Medical • Encounter Lifecycle Subcontractor • Standard XI, Q8 Rendering and Service Code Samples.docx **Additional Documentation:** • AMA 2400.05 Encounter Data Submission CORPORATE USE ONLY	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• AMA 2400.15 Correction of Encounter Data in EMS CORPORATE USE ONLY • AMA 2400.20 Processing of Encounter Response File Info from Regulatory Agencies CORPORATE USE ONLY • S11 Element 8 & 9 Aetna Encounter Lifecycle • S11 Element 8 and 9 Vendor Lifecycle • S11R8 - Rendering and Service Code Data Samples	
MCE Description of Process: Finalized claims (paid/denied) are extracted from the Claims processing system once per week and imported into the Encounter Management System. Encounters are validated against compliance and business specific rules. Encounters not meeting compliance standards or meeting criteria for specific rules are held for additional review. All other encounters are batched, and files are created. Encounter files are created by vendors and sent to Aetna for submission to LDH. Once received, the files go through SNIP validation. If a file fails validation, it is returned to the vendor with an error report to correct the file. Once the files pass validation, they are loaded into Edifecs and submitted to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs. a. The member encounter data includes all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818.	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent months/quarters of submission compliance (acceptance/rejection reports) • Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source)	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. MCO: a. *Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH* PAHP: a. *Submit complete and accurate encounter data at least monthly.* PIHP: a. *Submit complete and accurate encounter data at least weekly* 42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1	• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • AETAMA 077955 2400.05 Encounter Data Submission • AETAMA 077963 2400.15 Correction of Encounter Data in the Encounter Management System • AETMA 077965 2400.20 Processing of Encounter Response File Information • Encounter Lifecycle Medical • Encounter Lifecycle Vendor • ABHLA Accuracy File Detail 2024.xlsx • Standard XI, Q9 Allowed and Paid Amount Fields Sample.docx • ABH-LA Encounter Reporting Sample 06.2025.pptx **Additional Documentation**: • AMA 2400.05 Encounter Data Submission CORPORATE USE ONLY • AMA 2400.15 Correction of Encounter Data in EMS CORPORATE USE ONLY • AMA 2400.20 Processing of Encounter Response File Info from Regulatory Agencies CORPORATE USE ONLY	

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• S11 Element 8 & 9 Aetna Encounter Lifecycle • S11 Element 8 and 9 Vendor Lifecycle • S11R9 ABH-LA Encounter Reporting Sample Revised Screen Shots 08112025 • S11R9 - Allowed and Paid Amount Fields Sample • S11R9 - ABHLA Accuracy File Detail 2024	
MCE Description of Process: Finalized claims (paid/denied) are extracted from the Claims processing system once per week and imported into the Encounter Management System. Encounters are validated against compliance and business specific rules. Encounters not meeting compliance standards or meeting criteria for specific rules are held for additional review. All other encounters are batched, and files are created. Encounter files are created by vendors and sent to Aetna for submission to LDH. Once received, the files go through SNIP validation. If a file fails validation, it is returned to the vendor with an error report to correct the file. Once the files pass validation, they are loaded into Edifecs and submitted to LDH. The excel document (ABHLA Accuracy File Detail) represents data from the Tableau dashboard which may be demonstrated, if needed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XI—Health Information Systems							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**100%**

Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation • S12R1-7,9,13 - 2025 QAPI Work Plan • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The health plan establishes and maintains a comprehensive QAPI program that is implemented annually through a collaboratively developed program description, work plan, and evaluation. These components are informed by input from all departments and are governed by a formal policy that ensures oversight, accountability, and continuous quality improvement across all services provided to members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Basic Elements of QAPI Programs		
2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) • Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports) **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 5-7, 77-78 • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation, pages 23, 24, 26, 29, 35, 103, 235, and 243-244 • S12R1-7,9,13 - 2025 QAPI Work Plan, line 24	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation • S12R2, 9-12 - QMOC 03.25.25 **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R2 2024 ABHLA QAPI Program Description, pg 106 • S12R2_UMC Meeting Minutes 08.14.2024 page 21 • S12R2 2024 ABHLA QAPI Program Evaluation, pg 260-262 • S12R2 - 2024 Quality Workplan Annotated, Line 24 / Description	
MCE Description of Process: The QAPI Program incorporates defined mechanisms to evaluate both underutilization and overutilization of services. These mechanisms are systematically applied to monitor service delivery patterns, identify variances, and support data-driven decisions that promote appropriate utilization and quality of care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 6,9,39 and 60 • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation • S12R1-7,9,13 - 2025 QAPI Work Plan, Line 25 • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation • S12R3-4 - A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R3 - 2024 Quality Workplan Annotated, Line 25 • S12R3 2024 QAPI Program Description, pgs. 6, 9, 39, 60, 63, & 121 • S12R3_UMC Meeting Minutes 2.5.2024 page 32 under special populations • S12R3 Case management Definitions for SHCN, pg. 73 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • ABH assesses quality of care through numerous programs and areas. The Health Needs Assessment is sent to all members to address care needs, and the Care Mgmt. team focuses on SHCN. UM has a trigger list with specific member codes which will trigger an automatic CM referral and members with care needs are also discussed during interdisciplinary rounds. • S12R3 2024 ABHLA QAPI Program Evaluation Final • S12R3_Health Needs Assessment_FINAL, entire document • S12R3 Comprehensive Assessment Care Plan Interview (CPI), entire document	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12R3_AMA 7500.07 Health Risk Screening Process Corporate Policy, entire document • S12R3_AMA 7500.07 Health Risk Screening Process Amendment, entire document • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R3 UM to CM Referral Trigger List, entire document • S12R3 Rounds PDHC, entire document • S12R3 IP Rounds Template with UM CM MD, entire document • S12R3 Inovalon QSI Tools_Redacted • S12R2_UMC Meeting Minutes 08.14.2024, entire document	
MCE Description of Process: The QAPI Program incorporates structured mechanisms to assess the quality and appropriateness of care delivered to members with special health care needs, as defined by the State's quality strategy. These assessments are conducted annually and are informed by multidisciplinary input through workgroups, committee reviews, and collaboration with provider partners to ensure that care meets established clinical standards and addresses the unique needs of this population.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including: a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Assessment tools	☐ Met ☐ Not Met ☒ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b) MCO Contract: NA PAHP Contract: None PIHP Contract: NA	• Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Medical record audit tools and results **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation • S12R1-7,9,13 - 2025 QAPI Work Plan • S12R1-7, 9 -A-LA 8000.01 QAPI Program Evaluation • S12R3-4 - A-LA 8000.90 Clinical Practice Guidelines and Preventive Services Guidelines • S12R4 - A-LA 8200.07 InterRater Reliability and Quality Assurance HEDIS Chart Abstraction • S12R4 - A-LA 8000.63 Provider Monitoring and Reporting	
MCE Description of Process: The QAPI Program includes defined mechanisms to assess the quality and appropriateness of care provided to members utilizing LTSS. These mechanisms encompass evaluations of care transitions across settings and comparisons of delivered services and supports against those outlined in each member's individualized treatment or service plan, as applicable.		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Performance Measurement		
5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually: a. Measures and reports to the State on its performance, using the standard measures required by the State; b. Submits to the State data, specified by the State, which enables the State to calculate the MCO's performance using the standard measures identified by the State; or c. Performs a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Performance measures reports • Evidence of submission of performance measurement reports to the State **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 15-17 • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation, pages 122-126 • S12R1-7,9,13 - 2025 QAPI Work Plan, Lines 2&3 • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation • S12R5 - DATAWORKBOOK12408 • S12R5 - IDSS Submission **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R5 A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects, pgs. 3, 5-6 • S12R5 A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects, pgs. 3, 5-6	
MCE Description of Process: The QAPI Program includes the annual collection, analysis, and submission of performance measurement data in accordance with State requirements. The health plan measures and reports its performance using State-specified standard metrics and submits data that enables the State to independently calculate performance outcomes. These activities are documented in the QAPI Program Description, Work Plan, and Evaluation, and are supported by internal reporting systems and oversight committees.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Performance Improvement Projects		
6. The QAPI program includes performance improvement projects (PIPs). a. The MCE conducts PIPs that focus on both clinical and nonclinical areas. MCO: a. *The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.*	**HSAG Required Evidence:** • Policies and procedures • QAPI Program Description • QAPI program work plan • QAPI program evaluation • List of all active PIPs, including which PIPs are considered clinical and non-clinical • Documentation for all active PIPs	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP shall perform a minimum of one LDH approved PIP.* 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2	**Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 58-69 • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation, pages 50-59 • S12R1-7,9,13 - 2025 QAPI Work Plan, Line 13 • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation • S12R6-8 - A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects • S12R6-7 - ABHLA PIP-Val_CCS_Quarter 1 4.30.2025 • S12R6-7 - ABHLA Congenital Syphilis Q1 4.30.2025 • S12R6-7 - ABHLA PIP –Val_Fluoride Varnish_Quarter 1 4.30.2025 • S12R6-7 - ABHLA Q1 2025 HIV Screening PIP • S12R6-7 - ABHLA_Q1 2025 BH TOC PIP **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R6 A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects	
MCE Description of Process: The health plan currently conducts five LDH-approved Performance Improvement Projects (PIPs), encompassing both clinical and nonclinical focus areas. Of these, four are clinical in nature, including at least one behavioral health PIP, in accordance with contractual and regulatory requirements. These projects are designed to achieve measurable and sustained improvements in health outcomes and service quality, as outlined in the QAPI Program Description and Work Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) 42 CFR §457.1240(b) MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3	**HSAG Required Evidence:** • QAPI program description • QAPI program work plan • QAPI program evaluation • Policies and procedures • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 61-62(Bold and Highlighted) • S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation • S12R1-7,9,13 - 2025 QAPI Work Plan, Line 13 • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• S12R6-8 - A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects • S12R6-7 - ABHLA PIP-Val_CCS_Quarter 1 4.30.2025 • S12R6-7 - ABHLA Congenital Syphilis Q1 4.30.2025 • S12R6-7 - ABHLA PIP –Val_Fluoride Varnish_Quarter 1 4.30.2025 • S12R6-7 - ABHLA Q1 2025 HIV Screening PIP • S12R6-7 - ABHLA_Q1 2025 BH TOC PIP **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R7 A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects • S12R7 2024 ABHLA QAPI Program Evaluation Final, pg 44-59	
MCE Description of Process: Each Performance Improvement Project (PIP) implemented by the health plan is designed to achieve measurable and sustained improvements in health outcomes and member satisfaction. These projects incorporate objective quality indicators, targeted interventions to enhance access and quality of care, and ongoing evaluation of intervention effectiveness. Planning activities are embedded to		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
support continuous or sustained improvement. Multidisciplinary workgroups, composed of subject matter experts from across departments, guide the development and execution of each PIP, with performance metrics reviewed and reported quarterly and annually to ensure accountability and alignment with State requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4	**HSAG Required Evidence:** • Policies and procedures • Evidence of annual submission of all PIPs to the State **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, page 61 (Bold and Highlighted) • S12R6-8 - A-LA 8400.05 Quality Improvement Activities Performance Improvement Projects **Additional Documentation:** • S12R8 8000.01 Quality Assessment Performance Improvement Evaluation refers to Improvement Evaluation policy that the PIPs are a part of the Evaluation that does state that it is submitted annually. • S12R8_LA2024_MCO_PIP-Val_HIV_Report_F1_0425 • S12R8_LA2024_MCO_PIP-Val_FV_Report_F1_0425	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• S12R8_LA2024_MCO_PIP-Val_CCS_Report_F1_0425 • S12R8_LA2024_MCO_PIP-Val_BH TOC_Report_F1_0425 • S12R8_LA2024_MCO_PIP-Val_Congenital_Syphilis_Report_F1_0425	
MCE Description of Process: The health plan reports the status and results of each Performance Improvement Project (PIP) to the State at least annually, in accordance with contractual requirements. In addition, quarterly updates are submitted to ensure timely communication of progress and outcomes, as requested by the State.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Critical Incidents		
9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b) MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Three examples of critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the MCE:** • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 69-70, and 71-72	☐ Met ☐ Not Met ☒ NA

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Requirement	**Supporting Documentation**	**Score**
	• S12R1-7, 9 - 2025 ABHLA QAPI Program Evaluation, page 60, • S12R1-7,9,13 - 2025 QAPI Work Plan, Line 16 • S12R1-7, 9 - A-LA 8000.01 QAPI Program Evaluation • S12R2, 9-12 - QMOC 03.25.25 minutes	
MCE Description of Process: The health plan actively participates in State-led efforts to prevent, detect, and remediate critical incidents in accordance with 42 CFR §441.302 and §441.730(a). This participation is embedded within the QAPI Program and includes documented policies and procedures, incident tracking and trending, and collaboration with providers and regulatory partners. The QAPI Program Description, Work Plan, and Evaluation reflect these activities, and quarterly updates are submitted to ensure timely communication of progress and outcomes.		
HSAG Findings: Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
QAPI Program Reviews, Analysis, and Evaluation		
10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. MCO: a. *The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.*	**HSAG Required Evidence:** • Committee meeting minutes (with discussion of QAPI evaluation) **Evidence as Submitted by the MCE:** • S12R2, 9-12 - QMOC 03.25.25	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(e) 42 CFR §457.1240(b) MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3 PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4		
MCE Description of Process: The health plan conducts an annual QAPI Program Evaluation to assess the impact and effectiveness of its quality initiatives. Each department contributes by evaluating the outcomes, performance trends, and barriers associated with their respective programs and interventions. The evaluation includes analysis of required performance measures, trended results from all Performance Improvement Projects (PIPs), and documentation of efforts to support community integration for members utilizing LTSS. The findings are reviewed by the Quality Management Oversight Committee and submitted to the governing body for oversight and strategic direction, in accordance with contractual and regulatory requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. QAPI Committee Requirements: MCO: a. *The MCO forms a QAPI Committee that at a minimum includes:* i. *The MCO's Medical Director who must serve as either the chairman or co-chairman;* ii. *The MCO's Behavioral Health Director;* iii. *Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;* iv. *Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and* v. *An Enrollee representative(s) and/or advocate(s).*	**HSAG Required Evidence:** • QAPI committee meeting minutes **Evidence as Submitted by the MCE:** • S12R2, 9-12 - QMOC 03.25.25 • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 24-25 **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PAHP: a. *The PAHP shall form a QAPI Committee that shall, at a minimum include:* i. *The Dental Director who must serve as either the chairman or co-chairman;* ii. *Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and* iii. *The PAHP shall include an enrollee advocate representative on the QAPI Committee.* PIHP: a. *The PIHP shall form a QAPI committee that shall, at a minimum include:* i. *The PIHP's Medical Director, who must serve as the chair or co-chair and* ii. *Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.* MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1	• S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R11 UMC Meeting Minutes 02.05.2024 • S12R11 QMOC Meeting Minutes 3.20.2024 • S12R11 2024 abhla_member_handbook_integrated_health • S12R11 provider_manual rev. 5.30.2024 • S12R11_Enrollee Advisory Committee minutes • S12R11_Enrollee Advisory Committee member site accesss • S12R11_Provider Advisory Committee_ provider site info	
MCE Description of Process: The health plan's QAPI Committee is chaired by the Chief Medical Officer and includes the Behavioral Health Medical Director as a voting member. The committee ensures broad representation from medical and behavioral health staff across various departments. In addition, the committee includes substantial involvement from medical and behavioral health providers who serve the plan's enrollees, as well as enrollee representatives and/or advocates, in alignment with contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
12. QAPI Committee Responsibilities: MCO: a. *The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:* i. *Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;* ii. *Ensure that QAPI activities take place throughout the MCO's organization and ensure that providers are involved in the QAPI Program;* iii. *Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;* iv. *Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;* v. *Designate evaluation and study design procedures;* vi. *Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;* vii. *Report findings to appropriate executive authority, staff, and departments within the MCO's organization;*	**HSAG Required Evidence:** • Policies and procedures • QAPI committee meeting minutes • Evidence of submission to the State • Evidence of working with other Contractor staff and Subcontractors • Evidence of updates to the Provider Manual • Evidence of provider network performance reviews • Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members' service utilization patterns **Evidence as Submitted by the MCE:** • S12R2, 9-12 - QMOC 03.25.25 • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, pages 22-25 **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
viii. *Direct and analyze periodic reviews of Enrollees' service utilization patterns;* ix. *Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;* x. *Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;* xi. *Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;* xii. *Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and* xiii. *Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.* PAHP: a. *The QAPI Committee shall:* i. *Meet on a quarterly basis;* ii. *Direct and review quality improvement (QI) activities;*	• S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R12 2024 ABHLA QAPI Program Description, pgs. 19-21	

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Requirement	**Supporting Documentation**	**Score**
iii. *Ensure that QAPI activities are implemented throughout the PAHP;* iv. *Review and suggest new and/or improved QI activities;* v. *Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;* vi. *Designate evaluation and study design procedures;* vii. *Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;* viii. *Report findings to appropriate executive authority, staff, and departments within the PAHP;* ix. *Direct and analyze periodic reviews of enrollees' service utilization patterns;* x. *Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and* xi. *Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.* PIHP: a. *QAPI committee responsibilities shall include:* i. *Directing and reviewing QI activities;* ii. *Ensuring that QAPI activities take place throughout the organization;* iii. *Suggesting new and/or improved QI activities;*		

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Requirement	**Supporting Documentation**	**Score**
iv. *Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;* v. *Conducting provider quality performance measure profiling;* vi. *Reporting findings to appropriate executive authority, staff, and departments within the PIHP;* vii. *Directing and analyzing periodic reviews of members' service utilization patterns; and* viii. *Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.* MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2		
MCE Description of Process: The health plan convenes the Quality Management Oversight Committee (QMOC) on at least a quarterly basis under the direction of the QAPI Program. The committee oversees and evaluates quality management and improvement activities across the organization, including provider participation. It reviews performance data, recommends policy decisions, initiates taskforces or workgroups to address identified concerns, and monitors service utilization trends. The committee also evaluates provider network performance, including primary care and behavioral health providers, and ensures appropriate follow-up on identified issues. The Chief Medical Officer chairs the committee and participates in the State's Quality Committee meetings. Written and signed minutes of all QMOC and subcommittee meetings are maintained and made available for LDH and accreditation reviews.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
13. QAPI Plan Requirements: MCO: a. *The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.* b. *The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.* c. *The QAPI Plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;* iv. *Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;* v. *Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and* vi. *Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects*	**HSAG Required Evidence:** • QAPI Plan • QAPI Program Description • Evidence of submission to the State **Evidence as Submitted by the MCE:** • S12R1-7,9,13 - 2025 QAPI Work Plan, c, i, column E, c, iii, column H & S • S12R1-7, 9 - 2025 ABHLA QAPI Program Description, page 13 **Additional Documentation:** • S12R1 2024 ABHLA QAPI Program Description, pg 5 • S12R1 2024 ABHLA QAPI Program Evaluation, entire document • S12R1 - 2024 Quality Workplan Annotated Line 2-4 • S12_7500.40 Members with Special Healthcare Needs Corporate Policy, entire document • S12R13 2024 ABHLA QAPI Program Description, pgs.12-16 • S12R13 - Report Submission_ 0136 Aetna 2024	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Network Providers' adherence to clinical practice guidelines as appropriate. PAHP: a. *The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.* b. *The QAPI plan shall be submitted to LDH annually, and prior to revisions.* c. *The QAPI plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and* iv. *Describe the role of providers in giving input to the QAPI Program.* PIHP: a. *The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Behavioral Health, Louisiana Department of Health (OBH). b. *The QAPI program description at a minimum, shall:* i. *Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.* ii. *Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.* iii. *Specify the remediation actions that will be implemented when system performance is less than the required threshold.* iv. *Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.* v. *Describe how the Contractor will obtain feedback from providers and members.* vi. *Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.* vii. *Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain*		

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Requirement	**Supporting Documentation**	**Score**
documentation from other state Medicaid programs or product lines operated by the Contractor. c. *The QAPI work plan at a minimum shall:* *Include objectives for the Contract year, inclusive of associated action steps and timelines.* i. *Include metrics and associated benchmarks for the wraparound agency scorecard.* ii. *Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.* iii. *Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator's (WF) demonstration of established wraparound competencies on a quarterly basis.* MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3		

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The QAPI Committee develops and implements a written QAPI Plan that incorporates the strategic direction provided by the governing body. The Plan is reviewed and approved annually by the Quality Management Oversight Committee (QMOC), with documentation reflected in committee minutes. In accordance with contractual requirements, the QAPI Plan is submitted to LDH during Readiness Review, annually thereafter, and prior to implementing any revisions. The Plan outlines a coordinated strategy for QAPI implementation, including planning, decision-making, intervention, and assessment of results. It also details evaluation metrics, staff roles and training, provider and enrollee input, and methods to ensure data validity and adherence to clinical guidelines specific to the Louisiana Medicaid Program.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1	=	11
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	**100%**

Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S13R1 - Member Handbook, Pages 77 - 78 • S13R1 A-LA 3100.90 Enrollee Grievance Policy, Pages 2 & 3	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: A Member Grievance is any written or verbal expression of dissatisfaction by a member, member representative including a provider authorized in writing to act on the member's behalf, including complaints about any matter other than an adverse benefit determination. The Appeal and Grievance department assumes primary responsibility for coordinating, managing and resolving member grievances, and for disseminating information to members about their grievance rights. Regardless of the department in which the information originates, all grievances are documented within Aetna Better Health's Appeal and Grievance Application and submitted on the date of receipt, with supporting documentation, to the Appeal and Grievance manager for review, referral, resolution, and reporting.		

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Requirement	**Supporting Documentation**	**Score**
The Appeal and Grievance department, in coordination with any affected department, will thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties including any clinical care involved. Aetna Better Health will resolve and respond to written grievances in writing and to oral grievance in writing at the members request within ninety (90) calendar days of the filing date, taking into consideration the urgency of the situation or whether the resolution timeframe has been extended. All members are advised in writing of the outcome of the investigation of the grievance, inclusive of the right to appeal through State fair hearing when appropriate. These rights are limited to those issues that present an adverse impact to the member, such as denial, reduction or termination of benefits or access to provider care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. A member may file a grievance with the MCE at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13R2 A-LA 3100.90 Enrollee Grievance Policy, Page 9 and Page 2 (Definition) • S13R2 - Personal Appeal Representative form • S13R2 - Submit Grievance form • S13R2 - Member Handbook, Pages 77 - 78	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health's Enrollee grievance system offers a grievance resolution process for resolving enrollee grievances when there is dissatisfaction with any service or care received by the enrollee. Enrollees or their representatives may submit grievances orally or in writing to any Aetna Better Health staff person. Standard grievances may be filed at any time. Expedited grievances		

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Requirement	**Supporting Documentation**	**Score**
related to the denial of expedited prior authorization or appeal processing; or related to Aetna Better Health taking an extension on the decision making timeframe for a prior authorization, or an appeal must be requested within sixty (60) calendar days of the Expedited Processing letter or the Extension letter. (Definition) Enrollee Representative A person who assists with the complaint/grievance on the enrollee's behalf including, but not limited to, a family member, friend, guardian, primary care practitioner (PCP), women's health care provider (WHCP) or an attorney. The enrollee must designate a representative in writing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCE:** • S13R3 A-LA 3100.90 Enrollee Grievance Policy • S13R3 - Member Handbook, Pages 77 - 78 • S13R3 - Submit Grievance form	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health's Enrollee grievance system offers a grievance resolution process for resolving enrollee grievances when there is dissatisfaction with any service or care received by the enrollee. Enrollees or their representatives may submit grievances orally or in writing to any Aetna Better Health staff person. Standard grievances may be filed at any time. Expedited grievances related to the denial of expedited prior authorization or appeal processing; or related to Aetna Better Health taking an extension on the decision making timeframe for a prior authorization, or an appeal must be requested within sixty (60) calendar days of the Expedited Processing letter or the Extension letter.		

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Requirement	**Supporting Documentation**	**Score**
(Definition) Enrollee Representative A person who assists with the complaint/grievance on the enrollee's behalf including, but not limited to, a family member, friend, guardian, primary care practitioner (PCP), women's health care provider (WHCP) or an attorney. The enrollee must designate a representative in writing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Grievances		
4. The MCE acknowledges receipt of each grievance. MCO and PAHP: a. *The MCO's/PAHP's process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.* PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13R4 A-LA 3100.90 Enrollee Grievance Policy, Page 9 • S13R4 Grievance Acknowledgment notice template • S13R4 A-LA 3100.90 Enrollee Grievance Policy, Reporting - Page 13	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health of Louisiana does not delegate grievance processing. Grievances may be submitted at any time to any member of Aetna Better Health of Louisiana staff or our contracted vendors. They may be submitted verbally by phone or in person		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
or in writing by email, mail, website or hard copy mail. Grievances are acknowledged in 5 business days in accordance with LA Contract section 2.15.2.2 All applicable departments or vendors are engaged as needed to resolve the grievance. Individuals who participate in the grievance resolution will not have been involved in any part of the issue that caused the grievance. Grievances are resolved within 90 days and notification of decision is sent within 2 days. See Page 9 of policy 3100.90. All verbal enrollee grievances are acknowledged verbally at the time of receipt All written enrollee grievances are acknowledged in writing within five (5) business days		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13R5a A-LA 3100.90 Enrollee Grievance Policy, Page 5 • S13R5c A-LA 3100.90 Enrollee Grievance Policy, Page 5 • S13R5 - LA A&G Organizational chart	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health of Louisiana does not delegate grievance processing. Grievances may be submitted at any time to any member of Aetna Better Health of Louisiana staff or our contracted vendors. They may be submitted verbally by phone or in person or in writing by email, mail, website or hard copy mail. Grievances are acknowledged in 5 business days in accordance with LA Contract section 2.15.2.2 All applicable departments or vendors are engaged as needed to resolve the grievance. Individuals who participate in the grievance resolution will not have been involved in any part of the issue that caused the grievance. See Page 5 of policy 3100.90. Aetna Better Health will verify that the individuals who determine a decision about grievances are individuals who were not involved in any previous level of review or decision-making and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the enrollee's condition or disease: (2.15.1.3) •A grievance regarding denial of expedited resolution of an appeal •A grievance that involves clinical issues The Grievance Committee reviews grievance trends and may resolve issues related to an expression of dissatisfaction filed by enrollees including the grievance request and all supporting documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Timely Resolution and Notification of Grievances		
6. The MCE resolves each grievance, and provides notice, as expeditiously as the member's health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408. MCO and PAHP Standard Grievances a. *The MCO/PAHP shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) Calendar Days from the date the MCO/PAHP receives the grievance.*	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Standard Grievances a. *For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.* 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12) MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1	**Evidence as Submitted by the MCE:** • S13R6 A-LA 3100.90 Enrollee Grievance Policy, Page 11 • S13R6 - Grievance Resolution Letter template	
MCE Description of Process: Aetna Better Health of Louisiana does not delegate grievance processing. Grievances may be submitted at any time to any member of Aetna Better Health of Louisiana staff or our contracted vendors. They may be submitted verbally by phone or in person or in writing by email, mail, website or hard copy mail. Grievances are acknowledged in 5 business days in accordance with LA Contract section 2.15.2.2. All applicable departments or vendors are engaged as needed to resolve the grievance. Individuals who participate in the grievance resolution will not have been involved in any part of the issue that caused the grievance. Grievances will be resolved within the following time frames and the enrollee will be notified orally the same day as resolution for expedited grievances and in writing within two (2) calendar days of resolution and within the established time frames below for all grievances, unless an extension of time is warranted. The timeframe for the disposition of a grievance and notice to the affected parties is as follows: • Within seventy-two (72) hours of receipt for clinically urgent situations or grievances related to when Aetna Better Health extends the timeframe for decision making or when the grievance is the result of the denial of expedited appeal decision making • Within ninety (90) calendar days of receipt for all other grievances Grievances will be resolved within ninety (90) calendar days and the affected parties notified within two (2) calendar days of resolution but will not exceed ninety (90) calendar days in accordance with LA Contract section 2.15.2.3.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of a grievance with extensions with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13R7 A-LA 3100.90 Enrollee Grievance Policy, Page 11 • No extensions requested	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health of Louisiana does not delegate grievance processing. Grievances may be submitted at any time to any member of Aetna Better Health of Louisiana staff or our contracted vendors. They may be submitted verbally by phone or in person or in writing by email, mail, website or hard copy mail. Grievances are acknowledged in 5 business days. All applicable departments or vendors are engaged as needed to resolve the grievance. Individuals who participate in the grievance resolution will not have been involved in any part of the issue that caused the grievance. The resolution time period may be extended up to fourteen (14) calendar days if: • The enrollee requests the extension • Aetna Better Health shows that there is a need for additional information and that the delay is in the enrollee's best interest • Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest • Aetna Better Health will provide written notice of the reason for the extension within two (2) calendar days from the date the decision to extend is made. The notice will inform the enrollee of their right to file a grievance if they disagree with the decision to extend		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • Two examples of grievances with extensions with oral and written notice • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13R8 A-LA 3100.90 Enrollee Grievance Policy, Page 11 • S13R8 - Grievance Extension letter • No grievances were extended for CY2024	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Aetna Better Health of Louisiana does not delegate grievance processing. Grievances may be submitted at any time to any member of Aetna Better Health of Louisiana staff or our contracted vendors. They may be submitted verbally by phone or in person or in writing by email, mail, website or hard copy mail. Grievances are acknowledged in 5 business days in accordance with LA Contract section 2.15.2.2 All applicable departments or vendors are engaged as needed to resolve the grievance. Individuals who participate in the grievance resolution will not have been involved in any part of the issue that caused the grievance. The resolution time period may be extended up to fourteen (14) calendar days if: • The enrollee requests the extension • Aetna Better Health shows that there is a need for additional information and that the delay is in the enrollee's best interest		

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Requirement	**Supporting Documentation**	**Score**
• Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest • Aetna Better Health will provide written notice of the reason for the extension within two (2) calendar days from the date the decision to extend is made. The notice will inform the enrollee of their right to file a grievance if they disagree with the decision to extend If the resolution timeframe is being extended and was not requested by the enrollee, Aetna Better Health must give written notice of the delay within the original ninety (90) calendar days. The timeframe for the standard disposition of a grievance and notice to the affected parties is one hundred four (104) calendar days from the day Aetna Better Health receives the grievance.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not include policy language that stated if the MCE extends the grievance resolution time frame not at the request of the member, the MCE would make reasonable efforts to give the member prompt oral notice of the delay.		
Required Actions: The MCE must include policy language that states, if the MCE extends the grievance resolution time frame not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days, gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision.		
Appeals General Requirements		
9. The MCE defines an appeal as a review by the MCE of an ABD. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Evidence as Submitted by the MCE: • S13R9 A-LA Member Appeal Policy, Page 2 • S13R9 - Member Handbook, Page 72 • S13R9 - Provider manual, Page 156	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: A request by a member or their representative for review and reconsideration of a decision with respect to an adverse benefit determination. The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. Appeals must be requested within sixty (60) calendar days from the date on the initial adverse benefit determination. This may also be referred to as notice of action.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13R10 A-LA Member Appeal Policy, Page 19 • S13R10 - Member Handbook, Page 76 • S13R10 - Provider Manual, Page 158	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: The appeal is reviewed and based on coverage or non-coverage and/or medical necessity, a decision is reached. Medical Necessity appeals are then approved and signed by Aetna Better Health's Medical Director or a physician designee. Non-clinical appeals are then decided by the Appeal and Grievance staff member. A written Appeal Decision Letter is sent to the member, their representative if designated and their treating practitioner as expeditiously as the member's health requires but not to exceed two (2) calendar days of the decision. If the decision is upheld, the Appeal Decision Letter explains the next level of appeal, which is the State fair hearing option.		
HSAG Findings: During the compliance review, HSAG identified that LDH's contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since State requirements differ from federal requirements. HSAG has communicated this information to LDH.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13R11 A-LA Member Appeal Policy, Page 17 • S13R11 - Member Handbook, Page 75 • S13R11 - Provider Manual, Page 158 • S13R11a - Provider Manual, Page 155 • S13R11a A-LA Member Appeal Policy, Page 17	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: A member or a member's representative may request an expedited appeal if they feel the timeframe required for a standard appeal could seriously jeopardize life or health, or the ability to attain, maintain or regain maximum function. For expedited appeal request, Aetna Better Health notifies the party filing the appeal, as soon as possible of all information that the plan requires to evaluate the appeal. Post-service appeals are not eligible for expedited processing. Aetna Better Health's medical director reviews the expedited appeal request, together with any supporting documentation submitted, as expeditiously as the member's health requires upon receipt of the request to determine if the case meets expedited urgency or need. In cases where the health plan determines a member's request meets expedited urgency or a practitioner supports the member's request, Aetna Better Health's medical director renders a decision as expeditiously as the member's health requires, within seventy-two (72) hours from the receipt of		

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Requirement	**Supporting Documentation**	**Score**
request. Aetna Better Health grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility. Aetna Better Health will make reasonable effort to communicate expedited decisions orally, followed by an electronic or written notification within two (2) calendar days66 of an initial oral notification and within the original seventy-two (72) hours. In addition, Aetna Better Health will make sure that punitive action is not taken in retaliation against a member who requests an appeal or a practitioner/provider who requests an expedited resolution or supports a member's appeal per contract section 2.15.4.11.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13R12 A-LA Member Appeal Policy, Page 2 • S13R12 - Member Handbook, Page 73 • S13R12 - Provider Manual, Page 157 • S13R12 - Notice of Action (redacted) • NoA is a Member ABD • S13R12 - Appeal Request form • S13R12_ABD Notice Template	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the date on the Notice of Adverse benefit determination.		

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Requirement	**Supporting Documentation**	**Score**
Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability. • Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt • Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request. • Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). • Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R13 A-LA Member Appeal Policy, Page 5 • S13R13 A-LA Member Appeal Policy, Page 73 • S13R13 - Personal Appeal Representative form	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the date on the Notice of Adverse benefit determination.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability. • Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt • Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request. • Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). • Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Appeals		
14. If the MCE denies a request for expedited resolution of an appeal, it: a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R14 A-LA Member Appeal Policy, Pages 18 – 19 • S13R14 - Provider Manual, Page 158 • S13R14 - Member Handbook, page 75 • S13R14 Expedited Appeal Request Denied Letter template	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2		
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. If a member or member's representative requests an expedited appeal and Aetna Better Health denies the request because it does not meet the expedited urgency or need, the appeal will be transferred processed and resolved in accordance with a non-expedited standard appeals process maintaining the original received date. The Appeal and Grievance coordinator will give the member and/or practitioner prompt oral notice of the denial and follow up within two (2) calendar days of receipt of request with a written notice that the appeal will be handled through the non-expedited standard process. The written notice of delay will include the member's right to file a grievance if they disagree with Aetna Better Health taking an extension.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE acknowledges receipt of each appeal. MCO and PAHP: a. *The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of*	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
each appeal unless the enrollee requests an expedited resolution. PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1	• HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R15 A-LA Member Appeal Policy, Page 11 • S13R15 - Member Handbook, Page 74 • S13R15 - Provider manual, Page 157 • S13R15 Appeal Acknowledgment Letter template • S13R15 2024 Tableau screenshot – Grievances • S13R15 2024 Tableau screenshot – Appeals • S13R15 Dec 2024-AnG Committee Minutes	

MCE Description of Process: Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the date on the Notice of Adverse benefit determination.

Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability.

• Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt
• Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request.
• Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal).
• Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and

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Requirement	**Supporting Documentation**	**Score**
requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. The MCE ensures that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of appeal staff members, including credentials • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R16a – c. A-LA Member Appeal Policy, Pages 13 – 15 • S13R16c - Member Handbook Member Handbook, Page 74 • S13R16 - LA A&G Organizational chart	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The decision to uphold a medical necessity denial requires review by a same-or-similar specialist. The same-or-similar specialist may be the same individual designated to make the appeal decision, or a separate reviewer who provides a recommendation to the individual making the decision as part of the appeal investigation. All practitioner types listed below can serve as a same-or-similar specialist. To be considered a same-or-similar specialist, the reviewing specialist's clinical training and experience, in relation to the subject of appeal, must: • Include treating the condition • Include treating complications that may result from the service or procedure • Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate The below requirements refer to clinical training and experience and therefore, experience that is limited to UM decision making is not considered sufficient experience and does not supersede the requirement for same-or-similar specialist review. Board certification in a specialty may be used as a proxy for clinical training and experience. <u>Medical Necessity Appeals</u> For appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision. The following practitioner types are considered appropriate for review of UM denial decisions for Aetna Better Health: •Physicians, all types: Medical, BH, pharmaceutical, dental, chiropractic and vision denials •Dentists: Dental denials These practitioners: •Are clinical peers as defined above •Hold an active, unrestricted license to practice medicine or a health profession; •Are board-certified (if applicable) by: −A specialty board approved by the American Board of Medical Specialties (doctors of medicine) −The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine) • Are chiropractors when reviewing chiropractic appeals <u>Non Clinical Appeals</u>		

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Requirement	**Supporting Documentation**	**Score**
For appeals that no not require medical necessity review, the final decision to uphold an appeal must be made by an individual who was not involved in the initial denial decision and is not subordinate to the individual who were not involved in any previous level of review or decision making.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The MCE treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R17 A-LA Member Appeal Policy, Page 11 • S13R17 – Member Handbook	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the date on the Notice of Adverse benefit determination. Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability. • Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt • Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request. • Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). • Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and		

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Requirement	**Supporting Documentation**	**Score**
requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R18 A-LA Member Appeal Policy, Page 15 • S13R18 - Member Handbook, Page 74 • S13R18 Appeal Acknowledgment Letter template • S13R18 - Notice of Action (redacted) • S13R12_ABD Notice Template	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than sixty (60) calendar days from the date on the Notice of Adverse benefit determination. A member may authorize anyone including but not limited to legal counsel, a relative, a friend, a practitioner/provider or other spokesperson to represent them to file an appeal on their behalf. Member assignment of an authorized representative must be in writing and on file with the health plan. •The member and/or the member's representative may present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date. The member and/or their representative may request to review the member's file or clinical records that will be		

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Requirement	**Supporting Documentation**	**Score**
presented to the appropriate person, persons or department before and or during the appeals process by contacting the Appeal and Grievance department. Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability. • Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt • Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request. • Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). • Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). MCO and PAHP:	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R19 - A-LA Member Appeal Policy, Page 15 • S13R19 - Member Handbook, Page 75	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. *Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request.* 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3	• S13R19 Appeal Acknowledgment Letter template	

MCE Description of Process: The member and/or the member's representative may present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date. The member and/or their representative may request to review the member's file or clinical records that will be presented to the appropriate person, persons or department before and or during the appeals process by contacting the Appeal and Grievance department.

Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802 or by submitting a request in writing. Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability.

• Aetna Better Health will acknowledge the receipt of expedited appeals verbally at the time of receipt
• Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) business days after receiving an appeal request.

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Requirement	**Supporting Documentation**	**Score**
• Oral inquiries seeking to appeal are treated as appeals. (to establish the earliest possible filing date for the appeal). • Upon receipt, each appeal request is assigned a tracking number, which is used by the Appeal and Grievance department to monitor each appeal throughout the research and resolution process. Aetna Better Health logs and tracks all appeals, expedited appeals, grievances and requests for fair hearings in the Appeal and Grievance Application. The content will be available to the Department in electronic format upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Resolution and Notification of Appeals		
20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal. 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Tracking documentation • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R20 A-LA Member Appeal Policy, Page 18 • S13R20 - Member Handbook, Page 74 • S13R20 2024 Tableau screenshot - Appeals	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. Aetna Better Health will resolve each appeal and provide an electronic or written notice of the appeal resolution, as expeditiously as the member's health condition requires but will not exceed:		

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Requirement	**Supporting Documentation**	**Score**
• Pre-service standard appeal: thirty (30) calendar days from the date the appeal is received • Post-service standard appeal: thirty (30) calendar days from the date the appeal is received		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal. 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R21 A-LA Member Appeal Policy, Page 17 • S13R21 - Member Handbook, Page 75 • S13R21 2024 Tableau screenshot - Appeals	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. For expedited appeal request, Aetna Better Health notifies the party filing the appeal, as soon as possible of all information that the plan requires to evaluate the appeal. Post-service appeals are not eligible for expedited processing. Aetna Better Health's medical director reviews the expedited appeal request, together with any supporting documentation submitted, as expeditiously as the member's health requires upon receipt of the request to determine if the case meets expedited urgency or need. In cases where the health plan determines a member's request meets expedited urgency or a practitioner supports the member's request, Aetna Better		

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Requirement	**Supporting Documentation**	**Score**
Health's medical director renders a decision as expeditiously as the member's health requires, within seventy-two (72) hours from the receipt of request. Aetna Better Health grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility. Aetna Better Health will make reasonable effort to communicate expedited decisions orally, followed by an electronic or written notification within two (2) calendar days of an initial oral notification and within the original seventy-two (72) hours.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if: a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R22 A-LA Member Appeal Policy, Page 18 • S13R22 - Member Handbook, Page 75 • S13R22 2024 Tableau screenshot - Appeals • No extensions on file	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended.		

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Requirement	**Supporting Documentation**	**Score**
Aetna Better Health may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension; or • Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest • Aetna Better Health will confirm the member's request for an extension in writing If the member requested an extension on an expedited appeal, Aetna will send the denial of expedited processing and transfer the case to standard processing maintaining the original received date.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Two examples of appeals with extended time frame with oral and written notice • Appeal extension template letter • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R23 A-LA Member Appeal Policy, Page 19 • S13R23 - Member Handbook, Page 75 • S13R23 Appeal Extension Letter • No extensions for CY 2024	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension; or • Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest • Aetna Better Health will confirm the member's request for an extension in writing If the member requested an extension on an expedited appeal, Aetna will send the denial of expedited processing and transfer the case to standard processing maintaining the original received date. • If the resolution timeframe is being extended and was not requested by the member, Aetna Better Health must make reasonable attempts to give oral notification of delay and must give written notice of the delay within two (2) calendar days of the decision to delay and within the original standard or expedited timeframe to the affected parties. The written notice of delay will include the member's right to file a grievance if they disagree with Aetna Better Health taking an extension.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R24 A-LA Member Appeal Policy, Page 2 • S13R24 - Provider Manual, Page 158 • S13R24 2024 Tableau screenshot – Appeals • S13R24 - Member Admin Appeal Approval - LA	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: In the case of a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) that fails to adhere to the notice and timing requirements for processing an appeal, the member is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The member may initiate a State fair hearing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
25. For all appeals, the MCE provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal. MCO: a. *The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.* b. *The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R25a & b A-LA Member Appeal Policy, Page 20 • S13R25 - Member Handbook, Page 76 • S13R25 - Member Medical Appeal Denial template **Additional Documentation:** • S13R25 - LDH Approval of Appeal Resolution Template.	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
c. *For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the enrollee of their right to seek a State Fair Hearing if the enrollee is not satisfied with the MCO's decision in response to an appeal, and the process for doing so.* PAHP: a. *The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.* b. *The PAHP shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.* c. *The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP's decision in response to an appeal, and the process for doing so.* 42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13		
MCE Description of Process: The written notice of the appeal resolution will be on the LDH approved template and include: • Unique appeal number • The results of the resolution process and the date it was completed		

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Requirement	**Supporting Documentation**	**Score**
• The specific reasons for the decision, in easily understandable language, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. If abbreviations are used, they are to be clearly explained in lay language. • For appeals not resolved wholly in the favor of the members, the right to request a State fair hearing and how to do so • The right to request a continuation of benefits while the hearing is pending and how to make the request • Notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's adverse benefit determination • A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based • Notification that the member can obtain, free of charge and, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based • Notification that the member is entitled to receive, free of charge and, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision • A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate. Participant names need not be included in the written notification to the members, but must be provided to members, upon request A description of the State fair hearing process along with any relevant written procedures; and • A description of the process to request that services continue while a State fair hearing is being processed, including that the member may be held financially liable for such services if the state upholds the denial decision		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice. MCO and PAHP: a. *In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.*	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R26 A-LA Member Appeal Policy, Page 17	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2		
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. If the resolution timeframe is being extended and was not requested by the member, Aetna Better Health must make reasonable attempts to give oral notification of delay and must give written notice of the delay within two (2) calendar days of the decision to delay and within the original standard or expedited timeframe to the affected parties. The written notice of delay will include the member's right to file a grievance if they disagree with Aetna Better Health taking an extension.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Fair Hearings and State External Review		
27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member. 42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03 MCO Contract: 2.15.1.11; 2.15.4.1	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the MCE:** • S13R27 A-LA Member Appeal Policy, Page 3 • S13R27 - Member Handbook, Page 76	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2	• S13R27 - Notice of Action (redacted) • S13R12_ABD Notice Template	
MCE Description of Process: The Notice of Adverse benefit determination explains the adverse benefit determination Aetna Better Health has taken or intends to take, the reasons for the adverse benefit determination; the right of the member or a representative acting on the member's behalf and with the member's written consent to file an appeal; the right to request a State fair hearing, procedures for exercising the rights to appeal or request a State fair hearing; the member may represent himself or use a family member, friend, guardian, practitioner/provider, legal counsel or other spokesperson; explain the specific regulations that support or the change in Federal or State law that requires the action; the member's right to request a state agency hearing, or in cases of an adverse benefit determination based on change in law, the circumstances under which a hearing will be granted; the circumstances under which an expedited resolution is available and how to request it; and the member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances under which the member may be required to pay the costs of these services. If the decision is upheld, the Appeal Decision Letter explains the next level of appeal, which is the State fair hearing option.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
28. The member has *120 calendar days* from the date of the MCE's notice of appeal resolution to request an SFH. MCO: a. *An enrollee or other party to the appeal, who has completed the MCO's appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R28 A-LA Member Appeal Policy, Page 21 • S13R28 - Member Handbook, Page 76 • S13R28 - Member Medical Appeal Denial template	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PAHP: a. *An enrollee or authorized representative, who has completed the PAHP's appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals.* PIHP: a. *The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP's notice of resolution.* 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2		
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended.		

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Requirement	**Supporting Documentation**	**Score**
A member or a representative acting on their behalf may request a State fair hearing within one hundred twenty (120) calendar days from the health plan's appeal decision letter. The member may request a State fair hearing through Division of Administrative Law upon exhaustion of the Aetna Better Health appeal process. This request must be completed within one hundred twenty (120) calendar days.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Continuation of Benefits		
29. The MCE continues the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. MCO/PAHP/PIHP: a. *Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.* *Timely files* means on or before the later of the following: within 10 calendar days of the MCE sending the notice of	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R29 A-LA Member Appeal Policy, Page 12 • S13R29 - Member Handbook, Page 76 • S13R29 - Notice of Action (Redacted) • S13R29 - Member Medical Appeal Denial template • S13R12_ABD Notice Template	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
ABD, or the intended effective date of the MCE's proposed ABD. 42 CFR §438.228 42 CFR §438.420(a-b) MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2		
MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. A member may continue to receive services for an ongoing course of treatment that were previously approved during the appeals process under the following circumstances: • The appeal is filed timely • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment • The member or their designed representative request continuation of benefits • The services were ordered by an authorized practitioner/provider; and • The original period covered by the original authorization has not expired. NOTE: As used here, "timely" filing means filing on or before the later of the following: • Within ten (10) calendar days of the health plan mailing the notice of adverse benefit determination • The intended effective date of the health plan's proposed adverse benefit determination		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
30. If, at the member's request, the MCE continues or reinstates the member's benefits while the appeal or	**HSAG Required Evidence:** • Policies and procedures • ABD notice template	☒ Met ☐ Not Met

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
SFH is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. MCO and PAHP: a. Appeals i. *The time period or service limits of a previously authorized service has been met.* 42 CFR §438.228 42 CFR §438.420(c) MCO Contract: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3	• HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R30 A-LA Member Appeal Policy, Page 13 • S13R30 - Member Handbook, Page 76 • S13R12_ABD Notice Template	☐ NA
MCE Description of Process: The health plan will continue the member's benefits until one of the following occurs: • The member withdraws the appeal • Ten (10) calendar days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached • A State fair hearing officer issues a hearing decision adverse to the member. • The time period or service limits of a previously authorized service has been met If the final resolution of the appeal is adverse to the member, that is, upholds Aetna Better Health's adverse benefit determination, Aetna Better Health may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
because of the requirements of this section. The member is informed that he/she can be financial liable for the services that were rendered during this process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE's ABD, the MCE may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE's contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420. 42 CFR §438.228 42 CFR §438.420(d) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R31 A-LA Member Appeal Policy, Page 13 • S13R31 - Member Handbook, Page 76 • S13R12_ABD Notice Template	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The health plan will continue the member's benefits until one of the following occurs: • The member withdraws the appeal • Ten (10) calendar days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached • A State fair hearing officer issues a hearing decision adverse to the member. • The time period or service limits of a previously authorized service has been met If the final resolution of the appeal is adverse to the member, that is, upholds Aetna Better Health's adverse benefit determination, Aetna Better Health may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. The member is informed that he/she can be financial liable for the services that were rendered during this process.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations. 42 CFR §438.228 42 CFR §438.424(b) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R32 A-LA Member Appeal Policy, Page 22 • S13R32 - Member Handbook, Page 76 • S13R32 – A&G Overturn Coordination Job Aid	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: If the State fair hearing officer reverses the decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Aetna Better Health will pay for those services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Reinstatement of Services		
33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i)	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13R33 A-LA Member Appeal Policy, Page 22	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1	• S13R33 Dec 2024-AnG Committee Minutes	
MCE Description of Process: If the State fair hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, Aetna Better Health will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires within seventy-two (72) hours of the notification of the overturn.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Grievances, Appeals, and State Fair Hearings		
34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Example of assistance to members on filing a grievance **Evidence as Submitted by the MCE:** • S13R34 A-LA Member Appeal Policy, Page 11 • S13R34 A-LA 3100.90 Enrollee Grievance Policy, Page 4 • S13R34 - Member Handbook, Page 72	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Aetna Better Health's Member Service department will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Teletypewriting Device for the Deaf/Teletypewriter (TTY/TDD) and interpreter capability.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 5.15.2; 5.15.3	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews **Evidence as Submitted by the MCE:** • S13R35 A-LA Member Appeal Policy, Page 7 • S13R35 A-LA 3100.90 Enrollee Grievance, Page 6 • S13R35 - Member Medical Appeal Denial template • S13R35 - Grievance Resolution Letter template • Flesch-Kincaid results attached to each file review	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The written notice of the appeal resolution will be on the LDH approved template and include: • Unique appeal number • The results of the resolution process and the date it was completed • The specific reasons for the decision, in easily understandable language, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. If abbreviations are used, they are to be clearly explained in lay language. • For appeals not resolved wholly in the favor of the members, the right to request a State fair hearing and how to do so • The right to request a continuation of benefits while the hearing is pending and how to make the request • Notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's adverse benefit determination • A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based • Notification that the member can obtain, free of charge and, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
• Notification that the member is entitled to receive, free of charge and, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision • A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate. Participant names need not be included in the written notification to the members, but must be provided to members, upon request • A description of the State fair hearing process along with any relevant written procedures; and • A description of the process to request that services continue while a State fair hearing is being processed, including that the member may be held financially liable for such services if the state upholds the denial decision Aetna Better Health will resolve and respond to written grievances in writing and to oral grievance in writing at the enrollees request within ninety (90) calendar days of the filing date, taking into consideration the urgency of the situation or whether the resolution timeframe has been extended.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g) MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template **Evidence as Submitted by the MCE:** • S13R36 A-LA 3100.90 Enrollee Grievance, Page 7 • S13R36 - Provider manual, Page 155 • S13R36 – ABHLA – HFI – RCA, pgs.15-17 • S13R36 – ABH LA Ancillary Contract Packet_highlighted.pdf	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• S13R36 – ABH LA Facility Contract Packet_highlighted.pdf • S13R36 – ABH LA Provider – Group Contract Packet_highlighted.pdf	
MCE Description of Process: Information regarding the grievance process is distributed to all contractors and to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
37. The MCE includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.3.1.6 PAHP Contract: 2.10.3.1.5 PIHP Contract: 11.4.2.4.2; 11.4.14.5	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the MCE:** • S13R37 A-LA Member Appeal Policy, Pages 15 & 22 • S13R37 A-LA 3100.90 Enrollee Grievance Policy, Page 7 • S13R12_ABD Notice Template • S13R37 – 2024 Member Handbook, pg. 76 • S13R37 - Member Involuntary Disenrollment - Washington (SFH)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate per Contract section 2.15.3.1.6 The parties to the State Fair Hearing include Aetna Better Health, the member and his or her representative or the representative of a deceased member's estate		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Recordkeeping Requirements		
38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. PIHP: a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members;	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration **Evidence as Submitted by the MCE:** • S13R38 A-LA Member Appeal Policy, Pages 15 – 16 • S13R38 A-LA 3100.90 Enrollee Grievance Policy, Page 10	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals; h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and i. The number of State Fair Hearings and resolution during the reporting period. 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2		

MCE Description of Process: The health plan advises members of their appeal rights and appeals process in the Member Handbook, the Notice of Adverse benefit determination, and on the website. The member is advised of appeal procedures in the written Notice of Adverse benefit determination that advises the member of the prior authorization decision on a service, procedure, equipment or medication was denied, reduced, terminated or suspended. Items are entered in the Appeal and Grievance Application, which is a highly customizable complaint, grievance and appeal application to capture, process, store, and retrieve detailed information on each complaint, grievance or appeal received.

The written notice of the appeal resolution will be on the LDH approved template and include:

- Unique appeal number
- The results of the resolution process and the date it was completed
- The specific reasons for the decision, in easily understandable language, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. If abbreviations are used, they are to be clearly explained in lay language.
- For appeals not resolved wholly in the favor of the members, the right to request a State fair hearing and how to do so
- The right to request a continuation of benefits while the hearing is pending and how to make the request
- Notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's adverse benefit determination
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
• Notification that the member can obtain, free of charge and, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based • Notification that the member is entitled to receive, free of charge and, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision • A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate. Participant names need not be included in the written notification to the members, but must be provided to members, upon request • A description of the State fair hearing process along with any relevant written procedures; and • A description of the process to request that services continue while a State fair hearing is being processed, including that the member may be held financially liable for such services if the state upholds the denial decision Aetna Better Health will resolve and respond to written grievances in writing and to oral grievance in writing at the enrollees request within ninety (90) calendar days of the filing date, taking into consideration the urgency of the situation or whether the resolution timeframe has been extended.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	36	X	1	=	36
	Not Met	=	1	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	**Total Score**		=	36

Total Score ÷ Total Applicable	=	**97%**

Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Certification		
1. Documentation or information the MCE submits to LDH is certified by the MCE's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful. b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b). 42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o) MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6	**HSAG Required Evidence:** • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification **Evidence as Submitted by the MCE:** • S14R1-Meeting Agenda from Q4 2024 ABHLA Regulatory Reporting Review 02DEC2024 • S14R1-A-LA 3000.26 Regulatory Report Management Policy, pg. 5. • S14R1-0039 ABH 2024 09 Report with concurrent attestation, see tab "Attestation and Notes" • S14R1-A-LA 3000.25 Contractually Required Staffing and Job Descriptions, pgs. 4 & 6.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABH maintains a regulatory report management policy to algin with the CFRs on who may attest/certify reporting. A meeting agenda from 2024 was included to demonstrate staff are educated on who can certify reports. The 0039 report demonstrates reports are certified at the time of submission. Policy no. A-LA 3000.25 is included with job descriptions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Compliance Program/Program Integrity Plan		
2. The MCE develops a compliance program that includes: a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements. b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors. c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract. d. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees, for the Federal and State standards and requirements under the Contract. MCO and PAHP: a. *Fraud, waste, and abuse training shall include, but not be limited to:* i. *Annual training of all employees; and* ii. *New hire training within thirty (30) Calendar Days of beginning date of employment.*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration **Evidence as Submitted by the MCE:** • S14R2-CVS Health Code of Conduct • S14R2-CVS Health Code of Conduct and Compliance Training • S14R2 - Code of Conduct Training Completed by ABHLA employees for CY2024 • S14R2-A-LA 3000.02 Compliance Officer Designation, pg. 1.	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
b. *The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:* i. *MCO/PAHP Code of Conduct Training;* ii. *Privacy and Security - Health Insurance Portability and Accountability Act;* iii. *Fraud, Waste, and Abuse identification and reporting procedures;* iv. *The False Claims Act and employee whistleblower protections;* v. *Procedures for Timely consistent exchange of information and collaboration with LDH;* vi. *Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and* vii. *Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.* c. *Effective lines of communication between the compliance officer and the organization's employees.*	• S14R2-A-LA 3000.25 Contractually Required Staffing and Job Descriptions, pg. 7. • S14R2-Louisiana_Fraud-Plan-Addendum_CY 2024 • S14R2-Compliance Committee Charter - ABHLA 2024 • S14R2-Org Chart • S14R2-ABH 2024 Aetna Medicaid Compliance Plan • S14R2-A-LA 3000.20 Compliance Training and Education, pgs. 5 & 7. • S14R2-A-LA 3000.12 Reporting Compliance Issues or Inquiries, pg. 3 and entire document.	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
d. *Enforcement of standards through well-publicized disciplinary guidelines.* e. *Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.* PIHP: a. *Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;* b. *A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;* c. *Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud; d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and* e. *Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.* 42 CFR §438.608(a)(1) MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7 PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9 PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11		
MCE Description of Process: Aetna Better Health's compliance program ensures adherence to federal and state Medicaid requirements through written policies, a dedicated Compliance Officer, and active oversight by quarterly compliance committee. All employees receive mandatory training on topics such as fraud, waste, and abuse, HIPAA, and whistleblower protections within 30 days of hire and annually thereafter. The program includes anonymous reporting channels, non-retaliation protections, and well-publicized disciplinary standards. Ongoing monitoring, risk assessments, and corrective action plans ensure prompt response to compliance issues and continuous improvement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP: a. *The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.* MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • S14R3-A-LA 3000.12 Reporting Compliance Issues or Inquiries Policy, pgs. 1, 2, 4, & 8. • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, pg. 3. • S14R3 - ABH 2024 Aetna Medicaid Compliance Plan, pgs. 29-30	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The 2024 SIU Anti-Fraud Plan outlines Aetna's comprehensive strategy to prevent, detect, investigate, and respond to healthcare fraud, waste, and abuse (FWA). The plan is led by a dedicated Special Investigations Unit (SIU) staffed with trained professionals and supported by advanced data analytics, internal audits, and collaborative efforts with LDH. The Compliance and Fraud programs include mandatory training for employees and contractors, multiple reporting mechanisms, and a structured investigative process with clear protocols for evidence collection and corrective action. The plan emphasizes confidentiality, compliance with federal and Louisiana state regulations, and continuous improvement through monitoring and education. ABH maintains a Fraud Plan Addendum which is updated yearly to reflect the requirements of the state contract and MCO Manual.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. Additional compliance program requirements: MCO: a. *The MCO's compliance program shall incorporate the following requirements:* i. *Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching,*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • S14R2-Louisiana_Fraud-Plan-Addendum_CY 2024, Sections 4.D, 4.G., 4.C, and 5.A.	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques. ii. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.* iii. *Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* iv. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.* PAHP: a. *Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing*	• S14R4 SIU OVERVIEW POLICY AETAMA-095064 • S14R4 SIU Investigations Policy AETAMA-094281 • S14R4 SIU Sampling AETAMA-094677 • S14R4 FWA P&P DOC-083389 • S14R4 FWA Indicators QPS-075505 • S14R4 SIU Compliance AETAMA-082008	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
patterns, monitoring claims edits, and other data mining techniques. b. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.* c. *Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.* e. *Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP's website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP's fraud, waste and abuse policies and procedures shall provide and certify that the PIHP's fraud, waste and abuse unit has access to records of providers.* i. *The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP's senior management.* b. *Description of effective training and education for the compliance officer, the organization's employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it* c. *A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.* MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12		
MCE Description of Process: Aetna's SIU Anti-Fraud Plan incorporates robust data analytics, including predictive modeling and anomaly detection, to identify potential Louisiana Medicaid fraud, waste, and abuse. The plan includes specific controls such as pre- and post-payment claims edits, provider flagging, and audit protocols to monitor billing patterns and prevent overpayments. Confidential reporting is supported through 24/7 hotlines, web forms, and email, with direct access to the SIU to ensure independence. Additionally, the SIU conducts both announced and unannounced provider site visits and audits to verify service delivery and billing integrity.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
5. Publicized email address: MCO and PAHP: a. *Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.* b. *The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.* MCO: a. *The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.* PAHP: a. *The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.* MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address **Evidence as Submitted by the MCE:** • S14R5-A-LA 3000.12 Reporting Compliance Issues or Inquiries Policy, pg. 3. • S14R5-CVS Health Code of Conduct and Compliance Training, pg. 8 • S14R5 - Code of Conduct Training Completed by ABHLA employees for CY2024 • S14R5-Q1 2024 ABHLA Compliance Training, pg. 8 • S14R5-A-LA 3000.20 Compliance Training and Education Policy, pg. 7. • S14R5-ABH 2024 Aetna Medicaid Compliance Plan, Section 5. **Additional Documentation:** • S14R5 - LDH Receipts of Compliance Plan • S14R5 – LDH Requesting Edits to Compliance Plan	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: ABHLA publicizes the email address for reporting fraud through the annual CVS Code of Conduct Training and the ABHLA Compliance Training. Furthermore, this information is contained in our policies.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH. 42 CFR §438.608(a)(2) MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9	**HSAG Required Evidence:** • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • S14R6-8 - CY 2023-2024 DRAFT FRG Methodology - Tracked Changes – 20230929 • S14S6-8 – FRGs CY 2024 Qs1-4 • S14R6-8 - AMA 3900.30 Reporting and Return of Overpayments • S14S6 – 0145 ABH 2024 Q1-4 • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, p.4 • S14R4 FWA P&P DOC-083389 • S14R4 SIU Sampling AETAMA-094677	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• S14R4 SIU Investigations Policy AETAMA-094281 • S14R4 SIU OVERVIEW POLICY AETAMA-095064 • S14R4 FWA Indicators QPS-075505 • S14R4 SIU Compliance AETAMA-082008	
MCE Description of Process: ABH reports all overpayments identified or recovered on a quarterly basis as demonstrated in S14S6 – 0145 ABH 2024 Q1-4. As demonstrated in the Louisiana Fraud Plan Addendum on p.4, ABH will report overpayments to LDH within 60 calendar days from the date the overpayment was identified.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments. b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. MCO:	**HSAG Required Evidence:** • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials • Most recent report of recoveries of overpayments to State **Evidence as Submitted by the MCE:** • S14R6-8 - CY 2023-2024 DRAFT FRG Methodology - Tracked Changes – 20230929 • S14S6-8 – FRGs CY 2024 Qs1-4 • S14R6-8 - AMA 3900.30 Reporting and Return of Overpayments, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
a. *Report annually to LDH, in a form and format specified by LDH, on the MCO's recoveries of overpayments in accordance with 42 CFR §438.608.* PAHP: a. *The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.* b. *The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* PIHP: a. *The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.* b. *The PIHP shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* 42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3) MCO Contract: 2.20.2.2.15; 2.20.7.3 PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6	• S14S6 – 0145 ABH 2024 Q1-4 • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, p.4	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABH adheres to federal and state requirements for the identification, reporting, and return of overpayments, including those related to fraud, waste, or abuse. Overpayments are reported and returned within 60 days of identification, in accordance with Section 6402 of the Affordable Care Act and LDH guidelines. ABH submits reports the 145 report to LDH on a quarterly basis with overpayment tracking. Financial reconciliations further ensure compliance with all applicable retention and reporting standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment. 42 CFR §438.608(d)(2) MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12	**HSAG Required Evidence:** • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • S14R6-8 - CY 2023-2024 DRAFT FRG Methodology - Tracked Changes – 20230929 • S14S6-8 – FRGs CY 2024 Qs1-4 • S14R6-8 - AMA 3900.30 Reporting and Return of Overpayments • S14S6 – 0145 ABH 2024 Q1-4 • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, p.4 • SR14R2 - SIU Training • S14R4 FWA P&P DOC-083389 • S14R4 SIU Sampling AETAMA-094677	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• S14R4 SIU Investigations Policy AETAMA-094281 • S14R4 SIU OVERVIEW POLICY AETAMA-095064 • S14R4 FWA Indicators QPS-075505 • S14R4 SIU Compliance AETAMA-082008	
MCE Description of Process: ABH submits the 0145 reports quarterly to LDH which include all identified and recouped overpayments for the previous quarter. This is demonstrated in S14S6 – 0145 ABH 2024 Q1-4 and S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, p.4. The overpayments process outlined in the policy ensures that network providers and health plans comply with federal and state requirements when an overpayment is identified, by the plan or the state. When an overpayment is identified, it must be reported and returned within 60 calendar days, along with a written explanation of the reason for the overpayment. Health plan receipts are reviewed monthly, and overpayments are reconciled and reported accordingly. Additionally, quarterly certifications are submitted by the health plan to confirm compliance with these requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. HSAG recommends that the MCE include this requirement in the provider manual.		
Required Actions: No action required.		
Notification of Member and Provider Changes		
9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member's circumstances that may affect the member's eligibility including all of the following: a. Changes in the member's residence; b. The death of a member.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • S14R09- Enrollment Discrepancy Desktop, pgs. 1, 3, & 5. • S14R9 - A LA 4500.43 Member Services Returned Mail, pgs. 2 & 4.	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.608(a)(3) MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4	• S14R9 – A-LA 4400.15 Enrollee Member Enrollment, pgs. 1-2.	
MCE Description of Process: The state has the exclusive authority to decide member enrollment. Enrollment discrepancies are reported according to the desktop process, and any member mail that is indicates the member has relocated out of the state is also reported.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE. PAHP: a. *The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services; and*	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • S14R10 - CCIG-0006 Exclusion Screening Policy 2024 External Version • S14R10 - A-LA 3000.24 Exclusion Screening Program Policy AMENDMENT • S14R10 - Desktop for Exclusion Checks v19FEB2024	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
ii. *The PAHP's plan for maintaining the quality of enrollee care, if the provider network change is likely to affect the delivery of covered services.* PIHP: a. *The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services, and* ii. *The PIHP's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.* 42 CFR §438.608(a)(4) MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5		
MCE Description of Process: Aetna Better Health implements a comprehensive exclusion screening process to identify and act on changes in a provider's eligibility status. Monthly screenings of employees, contractors, and network providers are conducted against federal and state exclusion lists, and any matches are verified and reported to LDH. The desktop providers a step-by-step process that details interdepartmental communication to ensure excluded providers are removed from the ABH's network.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Verification of Services Provided		
11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. MCO: a. *On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice shall specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished;* iv. *The amount of the payment made for the service; and* v. *The method for notifying the Contractor of services not rendered.* b. *The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available*	**HSAG Required Evidence:** • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials **Evidence as Submitted by the MCE:** • S14R11 - VOS Sampling Procedure/Training Document • S14R11 - 147 Paid Claim Counts Tech Specs Document for verifying services and sampling • S14R11 - 0147 ABH 2024 Q4 • S14R11 - VOS Sampling Procedure/Training Document **Additional Documentation:** • 0041 LA State Notification and Reporting Requirements-SIU Referrals to LDH	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis. c. *The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).* d. *The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* e. *Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the MCO's fraud and abuse department for review and to the LDH Program Integrity contact.* f. *Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.* PAHP:		

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Requirement	**Supporting Documentation**	**Score**
a. *On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manger that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis.* c. *The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and* d. *Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.* e. *Within three (3) business days, results indicating that paid services may not have been received shall be*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
referred to the PAHP's fraud and abuse department for review and to the LDH Program Integrity contact. f. *Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.* PIHP: a. *On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:* i. *The service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.* c. *Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g.,*		

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Requirement	**Supporting Documentation**	**Score**
case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim. d. *The Contractor shall over sample particular provider groups upon request by LDH.* e. *The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* f. *Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse department for review and to LDH's designated Program Integrity contact.* g. *The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH.* 42 CFR §438.608(a)(5) MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4		
MCE Description of Process: On the 5th of the month, the EOB Sampling is run and after the file is reviewed and approved the file is released in ARNA. At this point, letters are then mailed to a sampling of members (surveys are sent out to 5% of members with claims) to confirm that they received the services. This is an automated process. If a member calls to report that services were not received, Member Services sends those inquiries to SIU to investigate.		

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Requirement	**Supporting Documentation**	**Score**
Reports are run monthly and the report captures those services with a Call Description of "Verification of Services." Those calls identified are then sent to SIU to validate information, and are also reported quarterly and sent to LDH on Report 147.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Whistleblower Protection		
12. In the case of MCEs that make or receive annual payments under the contract of at least $5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. MCO: a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO's policies and procedures for detecting and preventing fraud, waste and abuse. 42 CFR §438.608(a)(6) MCO Contract: 6.18.1; 6.18.3 PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7 PIHP Contract: 13.1.1.2.; 13.1.2.8	**HSAG Required Evidence:** • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials **Evidence as Submitted by the MCE:** • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024, pg. 5-6. • S14R02-ABH 2024 Aetna Medicaid Compliance Plan, p. 10-11 • S14R12 – Colleague Handbook	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Aetna Better Health maintains written policies and procedures that comply with Section 1902(a)(68) of the Social Security Act, including detailed information about the Federal and State False Claims Acts and whistleblower protections. These policies are distributed to all employees, contractors, and agents, and are incorporated into colleague handbook. The policies outline the rights of employees to report suspected fraud, waste, and abuse without fear of retaliation and describe the procedures for detecting and preventing such activities. ABH ensures that all staff are educated on these laws and protections as part of its broader compliance and fraud prevention program. ABH demonstrates this in S14R02-ABH 2024 Aetna Medicaid Compliance Plan, p. 10-11.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Fraud, Waste, and Abuse		
13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures: a. That are designed to detect and prevent fraud, waste, and abuse. b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH's program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU). PAHP: a. *The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).*	**HSAG Required Evidence:** • Policies and procedures • Fraud, waste, and abuse plan • SIU workflow • Reporting mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • S14R13-ABHLA--HFI—RCA, pg 10 (FWA provisions) • S14R12 2024 SIU Anti-Fraud-Plan • S14R4 SIU Investigations Policy AETAMA-094281 p.5 • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 pg. 3-4	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process should be developed to expedite information for appropriate disposition.* 42 CFR §438.608(a) 42 CFR §438.608(a)(7) MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4		
MCE Description of Process: ABH promptly reports suspected Fraud, Waste, Abuse, and neglect information to the Louisiana Office of Attorney General MFCU and LDH as soon as practical after discovering suspected incidents, but no later than three (3) Business Days, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s). ABH demonstrates this in S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 pg. 3-4.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Suspension of Payments		
14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23. 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow • Staff training materials **Evidence as Submitted by the MCE:** • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 p.8 • S14R13-ABHLA--HFI—RCA • S14R16 Payment Suspension Template	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABH and/or its Subcontractors will suspend payment to a Network Provider when the State determines there is a credible allegation of Fraud, unless the State determines there is cause for not suspending payments to the Network Provider pending the investigation. ABHLA is responsible for sending the Network Provider the required notice and Appeal rights as required by 42 CFR §455.23. When ABH receives notification from LDH regarding a payment suspension, ABH will initiate the internal process of holding all future payments on the NPI or TIN provided by LDH. ABH will send a letter to the provider detailing the suspension as demonstrated in S14R16 Payment Suspension Template.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c). 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow, including applicable timeframes • Notice of payment suspension letter template • Staff training materials • HSAG will also use findings from the provider payment suspensions tracking system demonstration **Evidence as Submitted by the MCE:** • S14R3-Louisiana_Fraud-Plan-Addendum_CY 2024 p.8 • S14R16 Payment Suspension Template • S14R15-16 2000.25 LA Claims Adjudication Policy • S14R10 - Desktop for Exclusion Checks v19FEB2024 • S14R15 – Exclusion List Scrub Instructions	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA and/or its Subcontractors will suspend payment to a Network Provider when the State determines there is a credible allegation of Fraud, unless the State determines there is cause for not suspending payments to the Network Provider pending the investigation. Payment suspension is initiated internally, and the Payment Suspension letter is sent to the provider as demonstrated in S14R16 Payment Suspension Template.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Provider Screening and Enrollment Requirements		
16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E. 42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials **Evidence as Submitted by the MCE:** • S14R16 – ABHLA Ancillary / Group / Hospital Provider Contract Example(s) – Exhibit A: Louisiana Medicaid Regulatory Compliance Addendum Section – Section 2: Provider Services and Obligations – 2.2 - Exclusion, Suspension and/or Debarment and Screening • S14R16 - MCD Enrollment Workflow and Training Material • S14R16 – PES Walkthrough • S14R16 – Payment Suspension Template	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: ABHLA receives a daily Provider Enrollment File detailing network enrollment status directly from Gainwell. Provider Enrollment Status (PES) is ingested to the Provider Data Record. During Claims adjudication, the enrollment status is assessed, and claim is allowed to pay or deny based on most recent file update. The National Plan and Provider Enumeration System (NPPES) is a database maintained by the Centers for Medicare & Medicaid Services (CMS) that assigns and houses the unique National Provider Identification (NPI) number for providers. Provider Data Services (PDS) analysts use the NPPES system when processing pended claims when trying to confirm the Provider's billing information, taxonomy codes, specialties etc.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days. a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members. 42 CFR §438.602(b)(2) MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • S14R17 – AETNQM-081683 QM 54 LA • S14R17 – A0LA-6400.41 Assessment of Network Adequacy, Availability, and Access to Care Monitoring Plan • S14R17 – Credentialing Workflow 12.11.24 • S14R17 – louisiana_hpds(2) • S14R17 – abh_medicaid_inl_provider_cred_user_guide	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • S14R17 – 120 Day Deactivated Providers Exclusion Logic • S14R17 – LA Roster 05-29-25 FLOW CHART • S14R17 – Network Reviewing PES Requirement for Contracting	
MCE Description of Process: Aetna Better Health may execute network provider agreements for up to 120 days pending completion of screening, enrollment, and revalidation processes, in accordance with LDH and NCQA standards. If a provider is not enrolled within the 120-day period or is deemed ineligible by LDH, Aetna Better Health terminates the provider immediately and notifies affected members. This process is governed by the credentialing policy (QM 54 LA) and monitored through interdepartmental oversight, including the Quality Management Oversight Committee (QMOC). Compliance with these requirements is documented and reviewed regularly to ensure timely action and member protection.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Disclosures and Prohibited Affiliations		
18. The MCE, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104. c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. MCO:	**HSAG Required Evidence:** • Policies and procedures that apply to provider/contracted entities and the MCE • Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) • Disclosure of ownership and control notice template (required for completion by contracted entities) • Confirmation MCE disclosures were provided to LDH upon contract execution • Staff training materials	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
a. *Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars ($25,000), even if there is no suspicion of fraudulent activity.* 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610 MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13	**Evidence as Submitted by the MCE:** • S14R18 – ABHLA Ancillary / Group / Hospital Provider Contract Example(s) • S14R18 – Facility Creden Docs_11.24-DOO • S14R18 – Creden Docs Ancillary_11.24 - DOO • S14R18 – Provider-Group Creden Docs_11.24 - DOO • S14R18 – Shared-Disclosure of Ownership	
MCE Description of Process: During the contracting process, ABHLA submits to LDH a disclosure of ownership (DOO) for any material subcontract. The subcontractor has a duty to disclose its ownership, and that documentation is submitted to LDH. Due to the sensitive and proprietary nature of the documentation, we would need to discuss with LDH the best course of action for submission of an executed DOO, if necessary. However, we are able to provide the template.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	18	X	1	=	18
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	**Total Score**		=	18

Total Score ÷ Total Applicable	=	**100%**

Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	**Evidence as Submitted by the MCE**		**Score**
1. <Insert federal CFR citation> Contract: <Insert Citation(s)>	**MCE Document Submission:** •		☐ Met ☐ Not Met
HSAG Findings:			
Required Actions:			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			
Submission:			